

Calendar No. 683

105TH CONGRESS
2D Session

S. 2529

A BILL

Entitled the “Patients’ Bill of Rights Act of 1998”.

OCTOBER 2, 1998

Read the second time and placed on the calendar

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IN THE SENATE OF THE UNITED STATES

SEPTEMBER 29, 1998

Mr. DASCHLE (for himself and Mr. KENNEDY) introduced the following bill;
which was read the first time

OCTOBER 2, 1998

Read the second time and placed on the calendar

A BILL

Entitled the “Patients’ Bill of Rights Act of 1998”.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION. 1. SHORT TITLE.**

4 This bill may be cited as the “Patients’ Bill of Rights
5 Act of 1998”.

1 **Subtitle A—Health Insurance Bill**
2 **of Rights**

3 **CHAPTER 1—ACCESS TO CARE**

4 **SEC. 101. ACCESS TO EMERGENCY CARE.**

5 (a) COVERAGE OF EMERGENCY SERVICES.—

6 (1) IN GENERAL.—If a group health plan, or
7 health insurance coverage offered by a health insur-
8 ance issuer, provides any benefits with respect to
9 emergency services (as defined in paragraph (2)(B)),
10 the plan or issuer shall cover emergency services fur-
11 nished under the plan or coverage—

12 (A) without the need for any prior author-
13 ization determination;

14 (B) whether or not the health care pro-
15 vider furnishing such services is a participating
16 provider with respect to such services;

17 (C) in a manner so that, if such services
18 are provided to a participant, beneficiary, or en-
19 rollee by a nonparticipating health care provider
20 without prior authorization by the plan, the
21 participant, beneficiary, or enrollee is not liable
22 for amounts that exceed the amounts of liability
23 that would be incurred if the services were pro-
24 vided by a participating health care provider
25 with prior authorization by the plan; and

(D) without regard to any other term or condition of such coverage (other than exclusion or coordination of benefits, or an affiliation or waiting period, permitted under section 2701 of the Public Health Service Act, section 701 of the Employee Retirement Income Security Act of 1974, or section 9801 of the Internal Revenue Code of 1986, and other than applicable cost-sharing).

(2) DEFINITIONS.—In this section:

(A) EMERGENCY MEDICAL CONDITION BASED ON PRUDENT LAYPERSON STANDARD.—The term “emergency medical condition” means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act.

(B) EMERGENCY SERVICES.—The term “emergency services” means—

1 (i) a medical screening examination
2 (as required under section 1867 of the So-
3 cial Security Act) that is within the capa-
4 bility of the emergency department of a
5 hospital, including ancillary services rou-
6 tinely available to the emergency depart-
7 ment to evaluate an emergency medical
8 condition (as defined in subparagraph
9 (A)), and

10 (ii) within the capabilities of the staff
11 and facilities available at the hospital, such
12 further medical examination and treatment
13 as are required under section 1867 of such
14 Act to stabilize the patient.

15 (b) REIMBURSEMENT FOR MAINTENANCE CARE AND
16 POST-STABILIZATION CARE.—In the case of services
17 (other than emergency services) for which benefits are
18 available under a group health plan, or under health insur-
19 ance coverage offered by a health insurance issuer, the
20 plan or issuer shall provide for reimbursement with re-
21 spect to such services provided to a participant, bene-
22 ficiary, or enrollee other than through a participating
23 health care provider in a manner consistent with sub-
24 section (a)(1)(C) if the services are maintenance care or
25 post-stabilization care covered under the guidelines estab-

1 lished under section 1852(d)(2) of the Social Security Act
 2 (relating to promoting efficient and timely coordination of
 3 appropriate maintenance and post-stabilization care of an
 4 enrollee after an enrollee has been determined to be sta-
 5 ble), or, in the absence of guidelines under such section,
 6 such guidelines as the Secretary shall establish to carry
 7 out this subsection.

8 **SEC. 102. OFFERING OF CHOICE OF COVERAGE OPTIONS**
 9 **UNDER GROUP HEALTH PLANS.**

10 (a) REQUIREMENT.—

11 (1) OFFERING OF POINT-OF-SERVICE COV-
 12 ERAGE OPTION.—Except as provided in paragraph
 13 (2), if a group health plan (or health insurance cov-
 14 erage offered by a health insurance issuer in connec-
 15 tion with a group health plan) provides benefits only
 16 through participating health care providers, the plan
 17 or issuer shall offer the participant the option to
 18 purchase point-of-service coverage (as defined in
 19 subsection (b)) for all such benefits for which cov-
 20 erage is otherwise so limited. Such option shall be
 21 made available to the participant at the time of en-
 22 rollment under the plan or coverage and at such
 23 other times as the plan or issuer offers the partici-
 24 pant a choice of coverage options.

1 (2) EXCEPTION.—Paragraph (1) shall not
 2 apply with respect to a participant in a group health
 3 plan if the plan offers the participant—

4 (A) a choice of health insurance coverage;
 5 and

6 (B) one or more coverage options that do
 7 not provide benefits only through participating
 8 health care providers.

9 (b) POINT-OF-SERVICE COVERAGE DEFINED.—In
 10 this section, the term “point-of-service coverage” means,
 11 with respect to benefits covered under a group health plan
 12 or health insurance issuer, coverage of such benefits when
 13 provided by a nonparticipating health care provider. Such
 14 coverage need not include coverage of providers that the
 15 plan or issuer excludes because of fraud, quality, or similar
 16 reasons.

17 (c) CONSTRUCTION.—Nothing in this section shall be
 18 construed—

19 (1) as requiring coverage for benefits for a par-
 20 ticular type of health care provider;

21 (2) as requiring an employer to pay any costs
 22 as a result of this section or to make equal contribu-
 23 tions with respect to different health coverage op-
 24 tions; or

1 (3) as preventing a group health plan or health
 2 insurance issuer from imposing higher premiums or
 3 cost-sharing on a participant for the exercise of a
 4 point-of-service coverage option.

5 (d) NO REQUIREMENT FOR GUARANTEED AVAIL-
 6 ABILITY.—If a health insurance issuer offers health insur-
 7 ance coverage that includes point-of-service coverage with
 8 respect to an employer solely in order to meet the require-
 9 ment of subsection (a), nothing in section 2711(a)(1)(A)
 10 of the Public Health Service Act shall be construed as re-
 11 quiring the offering of such coverage with respect to an-
 12 other employer.

13 **SEC. 103. CHOICE OF PROVIDERS.**

14 (a) PRIMARY CARE.—A group health plan, and a
 15 health insurance issuer that offers health insurance cov-
 16 erage, shall permit each participant, beneficiary, and en-
 17 rollee to receive primary care from any participating pri-
 18 mary care provider who is available to accept such individ-
 19 ual.

20 (b) SPECIALISTS.—

21 (1) IN GENERAL.—Subject to paragraph (2), a
 22 group health plan and a health insurance issuer that
 23 offers health insurance coverage shall permit each
 24 participant, beneficiary, or enrollee to receive medi-
 25 cally necessary or appropriate specialty care, pursu-

1 ant to appropriate referral procedures, from any
 2 qualified participating health care provider who is
 3 available to accept such individual for such care.

4 (2) LIMITATION.—Paragraph (1) shall not
 5 apply to specialty care if the plan or issuer clearly
 6 informs participants, beneficiaries, and enrollees of
 7 the limitations on choice of participating providers
 8 with respect to such care.

9 **SEC. 104. ACCESS TO SPECIALTY CARE.**

10 (a) OBSTETRICAL AND GYNECOLOGICAL CARE.—

11 (1) IN GENERAL.—If a group health plan, or a
 12 health insurance issuer in connection with the provi-
 13 sion of health insurance coverage, requires or pro-
 14 vides for a participant, beneficiary, or enrollee to
 15 designate a participating primary care provider—

16 (A) the plan or issuer shall permit such an
 17 individual who is a female to designate a par-
 18 ticipating physician who specializes in obstetrics
 19 and gynecology as the individual’s primary care
 20 provider; and

21 (B) if such an individual has not des-
 22 ignated such a provider as a primary care pro-
 23 vider, the plan or issuer—

24 (i) may not require authorization or a
 25 referral by the individual’s primary care

1 provider or otherwise for coverage of rou-
 2 tine gynecological care (such as preventive
 3 women's health examinations) and preg-
 4 nancy-related services provided by a par-
 5 ticipating health care professional who spe-
 6 cializes in obstetrics and gynecology to the
 7 extent such care is otherwise covered, and

8 (ii) may treat the ordering of other
 9 gynecological care by such a participating
 10 physician as the authorization of the pri-
 11 mary care provider with respect to such
 12 care under the plan or coverage.

13 (2) CONSTRUCTION.—Nothing in paragraph
 14 (1)(B)(ii) shall waive any requirements of coverage
 15 relating to medical necessity or appropriateness with
 16 respect to coverage of gynecological care so ordered.

17 (b) PEDIATRIC CARE.—If a group health plan, or a
 18 health insurance issuer in connection with the provision
 19 of health insurance coverage, requires or provides for an
 20 enrollee to designate a participating primary care provider
 21 for a child of such enrollee the plan or issuer shall permit
 22 the enrollee to designate a physician who specializes in pe-
 23 diatrics as the child's primary care provider.

24 (c) SPECIALTY CARE.—

1 (1) SPECIALTY CARE FOR COVERED SERV-
2 ICES.—

3 (A) IN GENERAL.—If—

4 (i) an individual is a participant or
5 beneficiary under a group health plan or
6 an enrollee who is covered under health in-
7 surance coverage offered by a health insur-
8 ance issuer,

9 (ii) the individual has a condition or
10 disease of sufficient seriousness and com-
11 plexity to require treatment by a specialist,
12 and

13 (iii) benefits for such treatment are
14 provided under the plan or coverage,

15 the plan or issuer shall make or provide for a
16 referral to a specialist who is available and ac-
17 cessible to provide the treatment for such condi-
18 tion or disease.

19 (B) SPECIALIST DEFINED.—For purposes
20 of this subsection, the term “specialist” means,
21 with respect to a condition, a health care practi-
22 tioner, facility, or center (such as a center of
23 excellence) that has adequate expertise through
24 appropriate training and experience (including,
25 in the case of a child, appropriate pediatric ex-

1 pertise) to provide high quality care in treating
2 the condition.

3 (C) CARE UNDER REFERRAL.—A group
4 health plan or health insurance issuer may re-
5 quire that the care provided to an individual
6 pursuant to such referral under subparagraph
7 (A) be—

8 (i) pursuant to a treatment plan, only
9 if the treatment plan is developed by the
10 specialist and approved by the plan or
11 issuer, in consultation with the designated
12 primary care provider or specialist and the
13 individual (or the individual's designee),
14 and

15 (ii) in accordance with applicable
16 quality assurance and utilization review
17 standards of the plan or issuer.

18 Nothing in this subsection shall be construed as
19 preventing such a treatment plan for an individ-
20 ual from requiring a specialist to provide the
21 primary care provider with regular updates on
22 the specialty care provided, as well as all nec-
23 essary medical information.

24 (D) REFERRALS TO PARTICIPATING PRO-
25 VIDERS.—A group health plan or health insur-

1 ance issuer is not required under subparagraph
 2 (A) to provide for a referral to a specialist that
 3 is not a participating provider, unless the plan
 4 or issuer does not have an appropriate specialist
 5 that is available and accessible to treat the indi-
 6 vidual's condition and that is a participating
 7 provider with respect to such treatment.

8 (E) TREATMENT OF NONPARTICIPATING
 9 PROVIDERS.—If a plan or issuer refers an indi-
 10 vidual to a nonparticipating specialist pursuant
 11 to subparagraph (A), services provided pursu-
 12 ant to the approved treatment plan (if any)
 13 shall be provided at no additional cost to the in-
 14 dividual beyond what the individual would oth-
 15 erwise pay for services received by such a spe-
 16 cialist that is a participating provider.

17 (2) SPECIALISTS AS PRIMARY CARE PROVID-
 18 ERS.—

19 (A) IN GENERAL.—A group health plan, or
 20 a health insurance issuer, in connection with
 21 the provision of health insurance coverage, shall
 22 have a procedure by which an individual who is
 23 a participant, beneficiary, or enrollee and who
 24 has an ongoing special condition (as defined in
 25 subparagraph (C)) may receive a referral to a

1 specialist for such condition who shall be re-
2 sponsible for and capable of providing and co-
3 ordinating the individual's primary and spe-
4 cialty care. If such an individual's care would
5 most appropriately be coordinated by such a
6 specialist, such plan or issuer shall refer the in-
7 dividual to such specialist.

8 (B) TREATMENT AS PRIMARY CARE PRO-
9 VIDER.—Such specialist shall be permitted to
10 treat the individual without a referral from the
11 individual's primary care provider and may au-
12 thorize such referrals, procedures, tests, and
13 other medical services as the individual's pri-
14 mary care provider would otherwise be per-
15 mitted to provide or authorize, subject to the
16 terms of the treatment plan (referred to in
17 paragraph (1)(C)(i)).

18 (C) ONGOING SPECIAL CONDITION DE-
19 FINED.—In this paragraph, the term “special
20 condition” means a condition or disease that—

21 (i) is life-threatening, degenerative, or
22 disabling, and

23 (ii) requires specialized medical care
24 over a prolonged period of time.

1 (D) TERMS OF REFERRAL.—The provi-
 2 sions of subparagraphs (C) through (E) of
 3 paragraph (1) apply with respect to referrals
 4 under subparagraph (A) of this paragraph in
 5 the same manner as they apply to referrals
 6 under paragraph (1)(A).

7 (3) STANDING REFERRALS.—

8 (A) IN GENERAL.—A group health plan,
 9 and a health insurance issuer in connection
 10 with the provision of health insurance coverage,
 11 shall have a procedure by which an individual
 12 who is a participant, beneficiary, or enrollee
 13 and who has a condition that requires ongoing
 14 care from a specialist may receive a standing
 15 referral to such specialist for treatment of such
 16 condition. If the plan or issuer, or if the pri-
 17 mary care provider in consultation with the
 18 medical director of the plan or issuer and the
 19 specialist (if any), determines that such a
 20 standing referral is appropriate, the plan or
 21 issuer shall make such a referral to such a spe-
 22 cialist.

23 (B) TERMS OF REFERRAL.—The provi-
 24 sions of subparagraphs (C) through (E) of
 25 paragraph (1) apply with respect to referrals

1 under subparagraph (A) of this paragraph in
2 the same manner as they apply to referrals
3 under paragraph (1)(A).

4 **SEC. 105. CONTINUITY OF CARE.**

5 (a) IN GENERAL.—

6 (1) TERMINATION OF PROVIDER.—If a contract
7 between a group health plan, or a health insurance
8 issuer in connection with the provision of health in-
9 surance coverage, and a health care provider is ter-
10 minated (as defined in paragraph (3)), or benefits or
11 coverage provided by a health care provider are ter-
12 minated because of a change in the terms of pro-
13 vider participation in a group health plan, and an in-
14 dividual who is a participant, beneficiary, or enrollee
15 in the plan or coverage is undergoing a course of
16 treatment from the provider at the time of such ter-
17 mination, the plan or issuer shall—

18 (A) notify the individual on a timely basis
19 of such termination, and

20 (B) subject to subsection (c), permit the
21 individual to continue or be covered with re-
22 spect to the course of treatment with the pro-
23 vider during a transitional period (provided
24 under subsection (b)).

1 (2) TREATMENT OF TERMINATION OF CON-
 2 TRACT WITH HEALTH INSURANCE ISSUER.—If a
 3 contract for the provision of health insurance cov-
 4 erage between a group health plan and a health in-
 5 surance issuer is terminated and, as a result of such
 6 termination, coverage of services of a health care
 7 provider is terminated with respect to an individual,
 8 the provisions of paragraph (1) (and the succeeding
 9 provisions of this section) shall apply under the plan
 10 in the same manner as if there had been a contract
 11 between the plan and the provider that had been ter-
 12 minated, but only with respect to benefits that are
 13 covered under the plan after the contract termi-
 14 nation.

15 (3) TERMINATION.—In this section, the term
 16 “terminated” includes, with respect to a contract,
 17 the expiration or nonrenewal of the contract, but
 18 does not include a termination of the contract by the
 19 plan or issuer for failure to meet applicable quality
 20 standards or for fraud.

21 (b) TRANSITIONAL PERIOD.—

22 (1) IN GENERAL.—Except as provided in para-
 23 graphs (2) through (4), the transitional period under
 24 this subsection shall extend for at least 90 days from

1 the date of the notice described in subsection
2 (a)(1)(A) of the provider's termination.

3 (2) INSTITUTIONAL CARE.—The transitional pe-
4 riod under this subsection for institutional or inpa-
5 tient care from a provider shall extend until the dis-
6 charge or termination of the period of institutional-
7 ization and also shall include institutional care pro-
8 vided within a reasonable time of the date of termi-
9 nation of the provider status if the care was sched-
10 uled before the date of the announcement of the ter-
11 mination of the provider status under subsection
12 (a)(1)(A) or if the individual on such date was on
13 an established waiting list or otherwise scheduled to
14 have such care.

15 (3) PREGNANCY.—If—

16 (A) a participant, beneficiary, or enrollee
17 has entered the second trimester of pregnancy
18 at the time of a provider's termination of par-
19 ticipation, and

20 (B) the provider was treating the preg-
21 nancy before date of the termination,
22 the transitional period under this subsection with re-
23 spect to provider's treatment of the pregnancy shall
24 extend through the provision of post-partum care di-
25 rectly related to the delivery.

1 (4) TERMINAL ILLNESS.—If—

2 (A) a participant, beneficiary, or enrollee
 3 was determined to be terminally ill (as deter-
 4 mined under section 1861(dd)(3)(A) of the So-
 5 cial Security Act) at the time of a provider’s
 6 termination of participation, and

7 (B) the provider was treating the terminal
 8 illness before the date of termination,
 9 the transitional period under this subsection shall
 10 extend for the remainder of the individual’s life for
 11 care directly related to the treatment of the terminal
 12 illness.

13 (c) PERMISSIBLE TERMS AND CONDITIONS.—A
 14 group health plan or health insurance issuer may condi-
 15 tion coverage of continued treatment by a provider under
 16 subsection (a)(1)(B) upon the provider agreeing to the fol-
 17 lowing terms and conditions:

18 (1) The provider agrees to accept reimburse-
 19 ment from the plan or issuer and individual involved
 20 (with respect to cost-sharing) at the rates applicable
 21 prior to the start of the transitional period as pay-
 22 ment in full (or, in the case described in subsection
 23 (a)(2), at the rates applicable under the replacement
 24 plan or issuer after the date of the termination of
 25 the contract with the health insurance issuer) and

1 not to impose cost-sharing with respect to the indi-
 2 vidual in an amount that would exceed the cost-shar-
 3 ing that could have been imposed if the contract re-
 4 ferred to in subsection (a)(1) had not been termi-
 5 nated.

6 (2) The provider agrees to adhere to the quality
 7 assurance standards of the plan or issuer responsible
 8 for payment under paragraph (1) and to provide to
 9 such plan or issuer necessary medical information
 10 related to the care provided.

11 (3) The provider agrees otherwise to adhere to
 12 such plan's or issuer's policies and procedures, in-
 13 cluding procedures regarding referrals and obtaining
 14 prior authorization and providing services pursuant
 15 to a treatment plan (if any) approved by the plan or
 16 issuer.

17 (d) CONSTRUCTION.—Nothing in this section shall be
 18 construed to require the coverage of benefits which would
 19 not have been covered if the provider involved remained
 20 a participating provider.

21 **SEC. 106. COVERAGE FOR INDIVIDUALS PARTICIPATING IN**
 22 **APPROVED CLINICAL TRIALS.**

23 (a) COVERAGE.—

24 (1) IN GENERAL.—If a group health plan, or
 25 health insurance issuer that is providing health in-

1 surance coverage, provides coverage to a qualified in-
2 dividual (as defined in subsection (b)), the plan or
3 issuer—

4 (A) may not deny the individual participa-
5 tion in the clinical trial referred to in subsection
6 (b)(2);

7 (B) subject to subsection (c), may not deny
8 (or limit or impose additional conditions on) the
9 coverage of routine patient costs for items and
10 services furnished in connection with participa-
11 tion in the trial; and

12 (C) may not discriminate against the indi-
13 vidual on the basis of the enrollee's participa-
14 tion in such trial.

15 (2) EXCLUSION OF CERTAIN COSTS.—For pur-
16 poses of paragraph (1)(B), routine patient costs do
17 not include the cost of the tests or measurements
18 conducted primarily for the purpose of the clinical
19 trial involved.

20 (3) USE OF IN-NETWORK PROVIDERS.—If one
21 or more participating providers is participating in a
22 clinical trial, nothing in paragraph (1) shall be con-
23 strued as preventing a plan or issuer from requiring
24 that a qualified individual participate in the trial
25 through such a participating provider if the provider

1 will accept the individual as a participant in the
2 trial.

3 (b) QUALIFIED INDIVIDUAL DEFINED.—For pur-
4 poses of subsection (a), the term “qualified individual”
5 means an individual who is a participant or beneficiary
6 in a group health plan, or who is an enrollee under health
7 insurance coverage, and who meets the following condi-
8 tions:

9 (1)(A) The individual has a life-threatening or
10 serious illness for which no standard treatment is ef-
11 fective.

12 (B) The individual is eligible to participate in
13 an approved clinical trial according to the trial pro-
14 tocol with respect to treatment of such illness.

15 (C) The individual’s participation in the trial
16 offers meaningful potential for significant clinical
17 benefit for the individual.

18 (2) Either—

19 (A) the referring physician is a participat-
20 ing health care professional and has concluded
21 that the individual’s participation in such trial
22 would be appropriate based upon the individual
23 meeting the conditions described in paragraph
24 (1); or

1 (B) the participant, beneficiary, or enrollee
 2 provides medical and scientific information es-
 3 tablishing that the individual’s participation in
 4 such trial would be appropriate based upon the
 5 individual meeting the conditions described in
 6 paragraph (1).

7 (c) PAYMENT.—

8 (1) IN GENERAL.—Under this section a group
 9 health plan or health insurance issuer shall provide
 10 for payment for routine patient costs described in
 11 subsection (a)(2) but is not required to pay for costs
 12 of items and services that are reasonably expected
 13 (as determined by the Secretary) to be paid for by
 14 the sponsors of an approved clinical trial.

15 (2) PAYMENT RATE.—In the case of covered
 16 items and services provided by—

17 (A) a participating provider, the payment
 18 rate shall be at the agreed upon rate, or

19 (B) a nonparticipating provider, the pay-
 20 ment rate shall be at the rate the plan or issuer
 21 would normally pay for comparable services
 22 under subparagraph (A).

23 (d) APPROVED CLINICAL TRIAL DEFINED.—

24 (1) IN GENERAL.—In this section, the term
 25 “approved clinical trial” means a clinical research

1 study or clinical investigation approved and funded
 2 (which may include funding through in-kind con-
 3 tributions) by one or more of the following:

4 (A) The National Institutes of Health.

5 (B) A cooperative group or center of the
 6 National Institutes of Health.

7 (C) Either of the following if the condi-
 8 tions described in paragraph (2) are met:

9 (i) The Department of Veterans Af-
 10 fairs.

11 (ii) The Department of Defense.

12 (2) CONDITIONS FOR DEPARTMENTS.—The
 13 conditions described in this paragraph, for a study
 14 or investigation conducted by a Department, are
 15 that the study or investigation has been reviewed
 16 and approved through a system of peer review that
 17 the Secretary determines—

18 (A) to be comparable to the system of peer
 19 review of studies and investigations used by the
 20 National Institutes of Health, and

21 (B) assures unbiased review of the highest
 22 scientific standards by qualified individuals who
 23 have no interest in the outcome of the review.

1 (e) CONSTRUCTION.—Nothing in this section shall be
 2 construed to limit a plan’s or issuer’s coverage with re-
 3 spect to clinical trials.

4 **SEC. 107. ACCESS TO NEEDED PRESCRIPTION DRUGS.**

5 (a) IN GENERAL.—If a group health plan, or health
 6 insurance issuer that offers health insurance coverage,
 7 provides benefits with respect to prescription drugs but
 8 the coverage limits such benefits to drugs included in a
 9 formulary, the plan or issuer shall—

10 (1) ensure participation of participating physi-
 11 cians and pharmacists in the development of the for-
 12 mulary;

13 (2) disclose to providers and, disclose upon re-
 14 quest under section 121(c)(6) to participants, bene-
 15 ficiaries, and enrollees, the nature of the formulary
 16 restrictions; and

17 (3) consistent with the standards for a utiliza-
 18 tion review program under section 115, provide for
 19 exceptions from the formulary limitation when a
 20 non-formulary alternative is medically indicated.

21 (b) COVERAGE OF APPROVED DRUGS AND MEDICAL
 22 DEVICES.—

23 (1) IN GENERAL.—A group health plan (or
 24 health insurance coverage offered in connection with
 25 such a plan) that provides any coverage of prescrip-

1 tion drugs or medical devices shall not deny coverage
2 of such a drug or device on the basis that the use
3 is investigational, if the use—

4 (A) in the case of a prescription drug—

5 (i) is included in the labeling author-
6 ized by the application in effect for the
7 drug pursuant to subsection (b) or (j) of
8 section 505 of the Federal Food, Drug,
9 and Cosmetic Act, without regard to any
10 postmarketing requirements that may
11 apply under such Act; or

12 (ii) is included in the labeling author-
13 ized by the application in effect for the
14 drug under section 351 of the Public
15 Health Service Act, without regard to any
16 postmarketing requirements that may
17 apply pursuant to such section; or

18 (B) in the case of a medical device, is in-
19 cluded in the labeling authorized by a regula-
20 tion under subsection (d) or (3) of section 513
21 of the Federal Food, Drug, and Cosmetic Act,
22 an order under subsection (f) of such section, or
23 an application approved under section 515 of
24 such Act, without regard to any postmarketing
25 requirements that may apply under such Act.

1 (2) CONSTRUCTION.—Nothing in this sub-
2 section shall be construed as requiring a group
3 health plan (or health insurance coverage offered in
4 connection with such a plan) to provide any coverage
5 of prescription drugs or medical devices.

6 **SEC. 108. ADEQUACY OF PROVIDER NETWORK.**

7 (a) IN GENERAL.—Each group health plan, and each
8 health insurance issuer offering health insurance coverage,
9 that provides benefits, in whole or in part, through partici-
10 pating health care providers shall have (in relation to the
11 coverage) a sufficient number, distribution, and variety of
12 qualified participating health care providers to ensure that
13 all covered health care services, including specialty serv-
14 ices, will be available and accessible in a timely manner
15 to all participants, beneficiaries, and enrollees under the
16 plan or coverage. This subsection shall only apply to a
17 plan’s or issuer’s application of restrictions on the partici-
18 pation of health care providers in a network and shall not
19 be construed as requiring a plan or issuer to create or
20 establish new health care providers in an area.

21 (b) TREATMENT OF CERTAIN PROVIDERS.—The
22 qualified health care providers under subsection (a) may
23 include Federally qualified health centers, rural health
24 clinics, migrant health centers, and other essential com-
25 munity providers located in the service area of the plan

1 or issuer and shall include such providers if necessary to
 2 meet the standards established to carry out such sub-
 3 section.

4 **SEC. 109. NONDISCRIMINATION IN DELIVERY OF SERVICES.**

5 (a) APPLICATION TO DELIVERY OF SERVICES.—Sub-
 6 ject to subsection (b), a group health plan, and health in-
 7 surance issuer in relation to health insurance coverage,
 8 may not discriminate against a participant, beneficiary, or
 9 enrollee in the delivery of health care services consistent
 10 with the benefits covered under the plan or coverage or
 11 as required by law based on race, color, ethnicity, national
 12 origin, religion, sex, age, mental or physical disability, sex-
 13 ual orientation, genetic information, or source of payment.

14 (b) CONSTRUCTION.—Nothing in subsection (a) shall
 15 be construed as relating to the eligibility to be covered,
 16 or the offering (or guaranteeing the offer) of coverage,
 17 under a plan or health insurance coverage, the application
 18 of any pre-existing condition exclusion consistent with ap-
 19 plicable law, or premiums charged under such plan or cov-
 20 erage.

21 **CHAPTER 2—QUALITY ASSURANCE**

22 **SEC. 111. INTERNAL QUALITY ASSURANCE PROGRAM.**

23 (a) REQUIREMENT.—A group health plan, and a
 24 health insurance issuer that offers health insurance cov-
 25 erage, shall establish and maintain an ongoing, internal

1 quality assurance and continuous quality improvement
 2 program that meets the requirements of subsection (b).

3 (b) PROGRAM REQUIREMENTS.—The requirements of
 4 this subsection for a quality improvement program of a
 5 plan or issuer are as follows:

6 (1) ADMINISTRATION.—The plan or issuer has
 7 a separate identifiable unit with responsibility for
 8 administration of the program.

9 (2) WRITTEN PLAN.—The plan or issuer has a
 10 written plan for the program that is updated annu-
 11 ally and that specifies at least the following:

12 (A) The activities to be conducted.

13 (B) The organizational structure.

14 (C) The duties of the medical director.

15 (D) Criteria and procedures for the assess-
 16 ment of quality.

17 (3) SYSTEMATIC REVIEW.—The program pro-
 18 vides for systematic review of the type of health
 19 services provided, consistency of services provided
 20 with good medical practice, and patient outcomes.

21 (4) QUALITY CRITERIA.—The program—

22 (A) uses criteria that are based on per-
 23 formance and patient outcomes where feasible
 24 and appropriate;

1 (B) includes criteria that are directed spe-
 2 cifically at meeting the needs of at-risk popu-
 3 lations and covered individuals with chronic
 4 conditions or severe illnesses, including gender-
 5 specific criteria and pediatric-specific criteria
 6 where available and appropriate;

7 (C) includes methods for informing covered
 8 individuals of the benefit of preventive care and
 9 what specific benefits with respect to preventive
 10 care are covered under the plan or coverage;
 11 and

12 (D) makes available to the public a de-
 13 scription of the criteria used under subpara-
 14 graph (A).

15 (5) SYSTEM FOR REPORTING.—The program
 16 has procedures for reporting of possible quality con-
 17 cerns by providers and enrollees and for remedial ac-
 18 tions to correct quality problems, including written
 19 procedures for responding to concerns and taking
 20 appropriate corrective action.

21 (6) DATA ANALYSIS.—The program provides,
 22 using data that include the data collected under sec-
 23 tion 112, for an analysis of the plan's or issuer's
 24 performance on quality measures.

1 (7) DRUG UTILIZATION REVIEW.—The program
2 provides for a drug utilization review program in ac-
3 cordance with section 114.

4 (c) DEEMING.—For purposes of subsection (a), the
5 requirements of—

6 (1) subsection (b) (other than paragraph (5))
7 are deemed to be met with respect to a health insur-
8 ance issuer that is a qualified health maintenance
9 organization (as defined in section 1310(c) of the
10 Public Health Service Act); or

11 (2) subsection (b) are deemed to be met with
12 respect to a health insurance issuer that is accred-
13 ited by a national accreditation organization that the
14 Secretary certifies as applying, as a condition of cer-
15 tification, standards at least as stringent as those
16 required for a quality improvement program under
17 subsection (b).

18 (d) VARIATION PERMITTED.—The Secretary may
19 provide for variations in the application of the require-
20 ments of this section to group health plans and health in-
21 surance issuers based upon differences in the delivery sys-
22 tem among such plans and issuers as the Secretary deems
23 appropriate.

1 **SEC. 112. COLLECTION OF STANDARDIZED DATA.**

2 (a) IN GENERAL.—A group health plan and a health
3 insurance issuer that offers health insurance coverage
4 shall collect uniform quality data that include a minimum
5 uniform data set described in subsection (b).

6 (b) MINIMUM UNIFORM DATA SET.—The Secretary
7 shall specify (and may from time to time update) the data
8 required to be included in the minimum uniform data set
9 under subsection (a) and the standard format for such
10 data. Such data shall include at least—

11 (1) aggregate utilization data;

12 (2) data on the demographic characteristics of
13 participants, beneficiaries, and enrollees;

14 (3) data on disease-specific and age-specific
15 mortality rates and (to the extent feasible) morbidity
16 rates of such individuals;

17 (4) data on satisfaction of such individuals (in-
18 cluding satisfaction with respect to services to chil-
19 dren), including data on voluntary disenrollment and
20 grievances; and

21 (5) data on quality indicators and health out-
22 comes, including, to the extent feasible and appro-
23 priate, data on pediatric cases and on a gender-spe-
24 cific basis.

25 (c) AVAILABILITY.—A summary of the data collected
26 under subsection (a) shall be disclosed under section

1 121(b)(9). The Secretary shall be provided access to all
 2 the data so collected.

3 (d) VARIATION PERMITTED.—The Secretary may
 4 provide for variations in the application of the require-
 5 ments of this section to group health plans and health in-
 6 surance issuers based upon differences in the delivery sys-
 7 tem among such plans and issuers as the Secretary deems
 8 appropriate.

9 **SEC. 113. PROCESS FOR SELECTION OF PROVIDERS.**

10 (a) IN GENERAL.—A group health plan and a health
 11 insurance issuer that offers health insurance coverage
 12 shall, if it provides benefits through participating health
 13 care professionals, have a written process for the selection
 14 of participating health care professionals, including mini-
 15 mum professional requirements.

16 (b) VERIFICATION OF BACKGROUND.—Such process
 17 shall include verification of a health care provider’s license
 18 and a history of suspension or revocation.

19 (c) RESTRICTION.—Such process shall not use a
 20 high-risk patient base or location of a provider in an area
 21 with residents with poorer health status as a basis for ex-
 22 cluding providers from participation.

23 (d) NONDISCRIMINATION BASED ON LICENSURE.—

24 (1) IN GENERAL.—Such process shall not dis-
 25 criminate with respect to participation or indem-

nification as to any provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of such license or certification.

(2) CONSTRUCTION.—Paragraph (1) shall not be construed—

(A) as requiring the coverage under a plan or coverage of particular benefits or services or to prohibit a plan or issuer from including providers only to the extent necessary to meet the needs of the plan's or issuer's participants, beneficiaries, or enrollees or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the plan or issuer; or

(B) to override any State licensure or scope-of-practice law.

(e) GENERAL NONDISCRIMINATION.—

(1) IN GENERAL.—Subject to paragraph (2), such process shall not discriminate with respect to selection of a health care professional to be a participating health care provider, or with respect to the terms and conditions of such participation, based on the professional's race, color, religion, sex, national origin, age, sexual orientation, or disability (consist-

1 ent with the Americans with Disabilities Act of
2 1990).

3 (2) RULES.—The appropriate Secretary may
4 establish such definitions, rules, and exceptions as
5 may be appropriate to carry out paragraph (1), tak-
6 ing into account comparable definitions, rules, and
7 exceptions in effect under employment-based non-
8 discrimination laws and regulations that relate to
9 each of the particular bases for discrimination de-
10 scribed in such paragraph.

11 **SEC. 114. DRUG UTILIZATION PROGRAM.**

12 A group health plan, and a health insurance issuer
13 that provides health insurance coverage, that includes ben-
14 efits for prescription drugs shall establish and maintain,
15 as part of its internal quality assurance and continuous
16 quality improvement program under section 111, a drug
17 utilization program which—

18 (1) encourages appropriate use of prescription
19 drugs by participants, beneficiaries, and enrollees
20 and providers, and

21 (2) takes appropriate action to reduce the inci-
22 dence of improper drug use and adverse drug reac-
23 tions and interactions.

1 **SEC. 115. STANDARDS FOR UTILIZATION REVIEW ACTIVITIES.**
2 **TIES.**

3 (a) COMPLIANCE WITH REQUIREMENTS.—

4 (1) IN GENERAL.—A group health plan, and a
5 health insurance issuer that provides health insurance coverage, shall conduct utilization review activities in connection with the provision of benefits
6 under such plan or coverage only in accordance with
7 a utilization review program that meets the requirements of this section.
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11 (2) USE OF OUTSIDE AGENTS.—Nothing in this
12 section shall be construed as preventing a group health plan or health insurance issuer from arranging through a contract or otherwise for persons or
13 entities to conduct utilization review activities on behalf of the plan or issuer, so long as such activities
14 are conducted in accordance with a utilization review program that meets the requirements of this section.
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19 (3) UTILIZATION REVIEW DEFINED.—For purposes of this section, the terms “utilization review”
20 and “utilization review activities” mean procedures
21 used to monitor or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of health care
22 services, procedures or settings, and includes prospective review, concurrent review, second opinions,
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1 case management, discharge planning, or retrospec-
2 tive review.

3 (b) WRITTEN POLICIES AND CRITERIA.—

4 (1) WRITTEN POLICIES.—A utilization review
5 program shall be conducted consistent with written
6 policies and procedures that govern all aspects of the
7 program.

8 (2) USE OF WRITTEN CRITERIA.—

9 (A) IN GENERAL.—Such a program shall
10 utilize written clinical review criteria developed
11 pursuant to the program with the input of ap-
12 propriate physicians. Such criteria shall include
13 written clinical review criteria described in sec-
14 tion 111(b)(4)(B).

15 (B) CONTINUING USE OF STANDARDS IN
16 RETROSPECTIVE REVIEW.—If a health care
17 service has been specifically pre-authorized or
18 approved for an enrollee under such a program,
19 the program shall not, pursuant to retrospective
20 review, revise or modify the specific standards,
21 criteria, or procedures used for the utilization
22 review for procedures, treatment, and services
23 delivered to the enrollee during the same course
24 of treatment.

25 (c) CONDUCT OF PROGRAM ACTIVITIES.—

1 (1) ADMINISTRATION BY HEALTH CARE PRO-
2 FESSIONALS.—A utilization review program shall be
3 administered by qualified health care professionals
4 who shall oversee review decisions. In this sub-
5 section, the term “health care professional” means a
6 physician or other health care practitioner licensed,
7 accredited, or certified to perform specified health
8 services consistent with State law.

9 (2) USE OF QUALIFIED, INDEPENDENT PER-
10 SONNEL.—

11 (A) IN GENERAL.—A utilization review
12 program shall provide for the conduct of utiliza-
13 tion review activities only through personnel
14 who are qualified and, to the extent required,
15 who have received appropriate training in the
16 conduct of such activities under the program.

17 (B) PEER REVIEW OF SAMPLE OF AD-
18 VERSE CLINICAL DETERMINATIONS.—Such a
19 program shall provide that clinical peers (as de-
20 fined in section 191(c)(2)) shall evaluate the
21 clinical appropriateness of at least a sample of
22 adverse clinical determinations.

23 (C) PROHIBITION OF CONTINGENT COM-
24 PENSATION ARRANGEMENTS.—Such a program
25 shall not, with respect to utilization review ac-

1 activities, permit or provide compensation or any-
 2 thing of value to its employees, agents, or con-
 3 tractors in a manner that—

4 (i) provides incentives, direct or indi-
 5 rect, for such persons to make inappropri-
 6 ate review decisions, or

7 (ii) is based, directly or indirectly, on
 8 the quantity or type of adverse determina-
 9 tions rendered.

10 (D) PROHIBITION OF CONFLICTS.—Such a
 11 program shall not permit a health care profes-
 12 sional who provides health care services to an
 13 individual to perform utilization review activi-
 14 ties in connection with the health care services
 15 being provided to the individual.

16 (3) ACCESSIBILITY OF REVIEW.—Such a pro-
 17 gram shall provide that appropriate personnel per-
 18 forming utilization review activities under the pro-
 19 gram are reasonably accessible by toll-free telephone
 20 during normal business hours to discuss patient care
 21 and allow response to telephone requests, and that
 22 appropriate provision is made to receive and respond
 23 promptly to calls received during other hours.

24 (4) LIMITS ON FREQUENCY.—Such a program
 25 shall not provide for the performance of utilization

1 review activities with respect to a class of services
2 furnished to an individual more frequently than is
3 reasonably required to assess whether the services
4 under review are medically necessary or appropriate.

5 (5) LIMITATION ON INFORMATION REQUESTS.—

6 Under such a program, information shall be required
7 to be provided by health care providers only to the
8 extent it is necessary to perform the utilization re-
9 view activity involved.

10 (d) DEADLINE FOR DETERMINATIONS.—

11 (1) PRIOR AUTHORIZATION SERVICES.—Except
12 as provided in paragraph (2), in the case of a utili-
13 zation review activity involving the prior authoriza-
14 tion of health care items and services for an individ-
15 ual, the utilization review program shall make a de-
16 termination concerning such authorization, and pro-
17 vide notice of the determination to the individual or
18 the individual's designee and the individual's health
19 care provider by telephone and in printed form, as
20 soon as possible in accordance with the medical ex-
21 igencies of the cases, and in no event later than 3
22 business days after the date of receipt of information
23 that is reasonably necessary to make such deter-
24 mination.

1 (2) CONTINUED CARE.—In the case of a utiliza-
2 tion review activity involving authorization for con-
3 tinued or extended health care services for an indi-
4 vidual, or additional services for an individual under-
5 going a course of continued treatment prescribed by
6 a health care provider, the utilization review pro-
7 gram shall make a determination concerning such
8 authorization, and provide notice of the determina-
9 tion to the individual or the individual's designee
10 and the individual's health care provider by tele-
11 phone and in printed form, as soon as possible in ac-
12 cordance with the medical exigencies of the cases,
13 and in no event later than 1 business day after the
14 date of receipt of information that is reasonably nec-
15 essary to make such determination. Such notice shall
16 include, with respect to continued or extended health
17 care services, the number of extended services ap-
18 proved, the new total of approved services, the date
19 of onset of services, and the next review date, if any.

20 (3) PREVIOUSLY PROVIDED SERVICES.—In the
21 case of a utilization review activity involving retro-
22 spective review of health care services previously pro-
23 vided for an individual, the utilization review pro-
24 gram shall make a determination concerning such
25 services, and provide notice of the determination to

1 the individual or the individual's designee and the
 2 individual's health care provider by telephone and in
 3 printed form, within 30 days of the date of receipt
 4 of information that is reasonably necessary to make
 5 such determination.

6 (4) REFERENCE TO SPECIAL RULES FOR EMER-
 7 GENCY SERVICES, MAINTENANCE CARE, AND POST-
 8 STABILIZATION CARE.—For waiver of prior author-
 9 ization requirements in certain cases involving emer-
 10 gency services and maintenance care and post-sta-
 11 bilization care, see subsections (a)(1) and (b) of sec-
 12 tion 101, respectively.

13 (e) NOTICE OF ADVERSE DETERMINATIONS.—

14 (1) IN GENERAL.—Notice of an adverse deter-
 15 mination under a utilization review program shall be
 16 provided in printed form and shall include—

17 (A) the reasons for the determination (in-
 18 cluding the clinical rationale);

19 (B) instructions on how to initiate an ap-
 20 peal under section 132; and

21 (C) notice of the availability, upon request
 22 of the individual (or the individual's designee)
 23 of the clinical review criteria relied upon to
 24 make such determination.

1 (2) SPECIFICATION OF ANY ADDITIONAL INFOR-
2 MATION.—Such a notice shall also specify what (if
3 any) additional necessary information must be pro-
4 vided to, or obtained by, the person making the de-
5 termination in order to make a decision on such an
6 appeal.

7 **SEC. 116. HEALTH CARE QUALITY ADVISORY BOARD.**

8 (a) ESTABLISHMENT.—The President shall establish
9 an advisory board to provide information to Congress and
10 the administration on issues relating to quality monitoring
11 and improvement in the health care provided under group
12 health plans and health insurance coverage.

13 (b) NUMBER AND APPOINTMENT.—The advisory
14 board shall be composed of the Secretary of Health and
15 Human Services (or the Secretary’s designee), the Sec-
16 retary of Labor (or the Secretary’s designee), and 20 addi-
17 tional members appointed by the President, in consulta-
18 tion with the Majority and Minority Leaders of the Senate
19 and House of Representatives. The members so appointed
20 shall include individuals with expertise in—

- 21 (1) consumer needs;
- 22 (2) education and training of health profes-
23 sionals;
- 24 (3) health care services;
- 25 (4) health plan management;

1 (5) health care accreditation, quality assurance,
2 improvement, measurement, and oversight;

3 (6) medical practice, including practicing physi-
4 cians;

5 (7) prevention and public health; and

6 (8) public and private group purchasing for
7 small and large employers or groups.

8 (c) DUTIES.—The advisory board shall—

9 (1) identify, update, and disseminate measures
10 of health care quality for group health plans and
11 health insurance issuers, including network and non-
12 network plans;

13 (2) advise the Secretary on the development
14 and maintenance of the minimum data set in section
15 112(b); and

16 (3) advise the Secretary on standardized for-
17 mats for information on group health plans and
18 health insurance coverage.

19 The measures identified under paragraph (1) may be used
20 on a voluntary basis by such plans and issuers. In carrying
21 out paragraph (1), the advisory board shall consult and
22 cooperate with national health care standard setting bod-
23 ies which define quality indicators, the Agency for Health
24 Care Policy and Research, the Institute of Medicine, and

1 other public and private entities that have expertise in
2 health care quality.

3 (d) REPORT.—The advisory board shall provide an
4 annual report to Congress and the President on the qual-
5 ity of the health care in the United States and national
6 and regional trends in health care quality. Such report
7 shall include a description of determinants of health care
8 quality and measurements of practice and quality varia-
9 bility within the United States.

10 (e) SECRETARIAL CONSULTATION.—In serving on
11 the advisory board, the Secretaries of Health and Human
12 Services and Labor (or their designees) shall consult with
13 the Secretaries responsible for other Federal health insur-
14 ance and health care programs.

15 (f) VACANCIES.—Any vacancy on the board shall be
16 filled in such manner as the original appointment. Mem-
17 bers of the board shall serve without compensation but
18 shall be reimbursed for travel, subsistence, and other nec-
19 essary expenses incurred by them in the performance of
20 their duties. Administrative support, scientific support,
21 and technical assistance for the advisory board shall be
22 provided by the Secretary of Health and Human Services.

23 (g) CONTINUATION.—Section 14(a)(2)(B) of the
24 Federal Advisory Committee Act (5 U.S.C. App.; relating

1 to the termination of advisory committees) shall not apply
 2 to the advisory board.

3 **CHAPTER 3—PATIENT INFORMATION**

4 **SEC. 121. PATIENT INFORMATION.**

5 (a) DISCLOSURE REQUIREMENT.—

6 (1) GROUP HEALTH PLANS.—A group health
 7 plan shall—

8 (A) provide to participants and bene-
 9 ficiaries at the time of initial coverage under
 10 the plan (or the effective date of this section, in
 11 the case of individuals who are participants or
 12 beneficiaries as of such date), and at least an-
 13 nually thereafter, the information described in
 14 subsection (b) in printed form;

15 (B) provide to participants and bene-
 16 ficiaries, within a reasonable period (as speci-
 17 fied by the appropriate Secretary) before or
 18 after the date of significant changes in the in-
 19 formation described in subsection (b), informa-
 20 tion in printed form on such significant
 21 changes; and

22 (C) upon request, make available to par-
 23 ticipants and beneficiaries, the applicable au-
 24 thority, and prospective participants and bene-

1 ficiaries, the information described in sub-
2 section (b) or (c) in printed form.

3 (2) HEALTH INSURANCE ISSUERS.—A health
4 insurance issuer in connection with the provision of
5 health insurance coverage shall—

6 (A) provide to individuals enrolled under
7 such coverage at the time of enrollment, and at
8 least annually thereafter, the information de-
9 scribed in subsection (b) in printed form;

10 (B) provide to enrollees, within a reason-
11 able period (as specified by the appropriate Sec-
12 retary) before or after the date of significant
13 changes in the information described in sub-
14 section (b), information in printed form on such
15 significant changes; and

16 (C) upon request, make available to the
17 applicable authority, to individuals who are pro-
18 spective enrollees, and to the public the infor-
19 mation described in subsection (b) or (c) in
20 printed form.

21 (b) INFORMATION PROVIDED.—The information de-
22 scribed in this subsection with respect to a group health
23 plan or health insurance coverage offered by a health in-
24 surance issuer includes the following:

1 (1) SERVICE AREA.—The service area of the
2 plan or issuer.

3 (2) BENEFITS.—Benefits offered under the
4 plan or coverage, including—

5 (A) covered benefits, including benefit lim-
6 its and coverage exclusions;

7 (B) cost sharing, such as deductibles, coin-
8 surance, and copayment amounts, including any
9 liability for balance billing, any maximum limi-
10 tations on out of pocket expenses, and the max-
11 imum out of pocket costs for services that are
12 provided by non participating providers or that
13 are furnished without meeting the applicable
14 utilization review requirements;

15 (C) the extent to which benefits may be ob-
16 tained from nonparticipating providers;

17 (D) the extent to which a participant, ben-
18 eficiary, or enrollee may select from among par-
19 ticipating providers and the types of providers
20 participating in the plan or issuer network;

21 (E) process for determining experimental
22 coverage; and

23 (F) use of a prescription drug formulary.

24 (3) ACCESS.—A description of the following:

1 (A) The number, mix, and distribution of
2 providers under the plan or coverage.

3 (B) Out-of-network coverage (if any) pro-
4 vided by the plan or coverage.

5 (C) Any point-of-service option (including
6 any supplemental premium or cost-sharing for
7 such option).

8 (D) The procedures for participants, bene-
9 ficiaries, and enrollees to select, access, and
10 change participating primary and specialty pro-
11 viders.

12 (E) The rights and procedures for obtain-
13 ing referrals (including standing referrals) to
14 participating and nonparticipating providers.

15 (F) The name, address, and telephone
16 number of participating health care providers
17 and an indication of whether each such provider
18 is available to accept new patients.

19 (G) Any limitations imposed on the selec-
20 tion of qualifying participating health care pro-
21 viders, including any limitations imposed under
22 section 103(b)(2).

23 (H) How the plan or issuer addresses the
24 needs of participants, beneficiaries, and enroll-
25 ees and others who do not speak English or

1 who have other special communications needs in
 2 accessing providers under the plan or coverage,
 3 including the provision of information described
 4 in this subsection and subsection (c) to such in-
 5 dividuals and including the provision of infor-
 6 mation in a language other than English if 5
 7 percent of the number of participants, bene-
 8 ficiaries, and enrollees communicate in that lan-
 9 guage instead of English.

10 (4) OUT-OF-AREA COVERAGE.—Out-of-area cov-
 11 erage provided by the plan or issuer.

12 (5) EMERGENCY COVERAGE.—Coverage of
 13 emergency services, including—

14 (A) the appropriate use of emergency serv-
 15 ices, including use of the 911 telephone system
 16 or its local equivalent in emergency situations
 17 and an explanation of what constitutes an
 18 emergency situation;

19 (B) the process and procedures of the plan
 20 or issuer for obtaining emergency services; and

21 (C) the locations of (i) emergency depart-
 22 ments, and (ii) other settings, in which plan
 23 physicians and hospitals provide emergency
 24 services and post-stabilization care.

1 (6) PERCENTAGE OF PREMIUMS USED FOR
2 BENEFITS (LOSS-RATIOS).—In the case of health in-
3 surance coverage only (and not with respect to group
4 health plans that do not provide coverage through
5 health insurance coverage), a description of the over-
6 all loss-ratio for the coverage (as defined in accord-
7 ance with rules established or recognized by the Sec-
8 retary of Health and Human Services).

9 (7) PRIOR AUTHORIZATION RULES.—Rules re-
10 garding prior authorization or other review require-
11 ments that could result in noncoverage or non-
12 payment.

13 (8) GRIEVANCE AND APPEALS PROCEDURES.—
14 All appeal or grievance rights and procedures under
15 the plan or coverage, including the method for filing
16 grievances and the time frames and circumstances
17 for acting on grievances and appeals, who is the ap-
18 plicable authority with respect to the plan or issuer,
19 and the availability of assistance through an om-
20 budsman to individuals in relation to group health
21 plans and health insurance coverage.

22 (9) QUALITY ASSURANCE.—A summary descrip-
23 tion of the data on quality collected under section
24 112(a), including a summary description of the data
25 on satisfaction of participants, beneficiaries, and en-

1 rollees (including data on individual voluntary
2 disenrollment and grievances and appeals) described
3 in section 112(b)(4).

4 (10) SUMMARY OF PROVIDER FINANCIAL IN-
5 CENTIVES.—A summary description of the informa-
6 tion on the types of financial payment incentives
7 (described in section 1852(j)(4) of the Social Secu-
8 rity Act) provided by the plan or issuer under the
9 coverage.

10 (11) INFORMATION ON ISSUER.—Notice of ap-
11 propriate mailing addresses and telephone numbers
12 to be used by participants, beneficiaries, and enroll-
13 ees in seeking information or authorization for treat-
14 ment.

15 (12) AVAILABILITY OF INFORMATION ON RE-
16 QUEST.—Notice that the information described in
17 subsection (c) is available upon request.

18 (c) INFORMATION MADE AVAILABLE UPON RE-
19 QUEST.—The information described in this subsection is
20 the following:

21 (1) UTILIZATION REVIEW ACTIVITIES.—A de-
22 scription of procedures used and requirements (in-
23 cluding circumstances, time frames, and appeal
24 rights) under any utilization review program under

1 section 115, including under any drug formulary
2 program under section 107.

3 (2) GRIEVANCE AND APPEALS INFORMATION.—
4 Information on the number of grievances and ap-
5 peals and on the disposition in the aggregate of such
6 matters.

7 (3) METHOD OF PHYSICIAN COMPENSATION.—
8 An overall summary description as to the method of
9 compensation of participating physicians, including
10 information on the types of financial payment incen-
11 tives (described in section 1852(j)(4) of the Social
12 Security Act) provided by the plan or issuer under
13 the coverage.

14 (4) SPECIFIC INFORMATION ON CREDENTIALS
15 OF PARTICIPATING PROVIDERS.—In the case of each
16 participating provider, a description of the creden-
17 tials of the provider.

18 (5) CONFIDENTIALITY POLICIES AND PROCE-
19 DURES.—A description of the policies and proce-
20 dures established to carry out section 122.

21 (6) FORMULARY RESTRICTIONS.—A description
22 of the nature of any drug formula restrictions.

23 (7) PARTICIPATING PROVIDER LIST.—A list of
24 current participating health care providers.

25 (d) FORM OF DISCLOSURE.—

1 (1) UNIFORMITY.—Information required to be
2 disclosed under this section shall be provided in ac-
3 cordance with uniform, national reporting standards
4 specified by the Secretary, after consultation with
5 applicable State authorities, so that prospective en-
6 rollees may compare the attributes of different
7 issuers and coverage offered within an area.

8 (2) INFORMATION INTO HANDBOOK.—Nothing
9 in this section shall be construed as preventing a
10 group health plan or health insurance issuer from
11 making the information under subsections (b) and
12 (c) available to participants, beneficiaries, and en-
13 rollees through an enrollee handbook or similar pub-
14 lication.

15 (3) UPDATING PARTICIPATING PROVIDER IN-
16 FORMATION.—The information on participating
17 health care providers described in subsection
18 (b)(3)(C) shall be updated within such reasonable
19 period as determined appropriate by the Secretary.
20 Nothing in this section shall prevent an issuer from
21 changing or updating other information made avail-
22 able under this section.

23 (e) CONSTRUCTION.—Nothing in this section shall be
24 construed as requiring public disclosure of individual con-

1 tracts or financial arrangements between a group health
 2 plan or health insurance issuer and any provider.

3 **SEC. 122. PROTECTION OF PATIENT CONFIDENTIALITY.**

4 Insofar as a group health plan, or a health insurance
 5 issuer that offers health insurance coverage, maintains
 6 medical records or other health information regarding par-
 7 ticipants, beneficiaries, and enrollees, the plan or issuer
 8 shall establish procedures—

9 (1) to safeguard the privacy of any individually
 10 identifiable enrollee information;

11 (2) to maintain such records and information in
 12 a manner that is accurate and timely, and

13 (3) to assure timely access of such individuals
 14 to such records and information.

15 **SEC. 123. HEALTH INSURANCE OMBUDSMEN.**

16 (a) IN GENERAL.—Each State that obtains a grant
 17 under subsection (c) shall provide for creation and oper-
 18 ation of a Health Insurance Ombudsman through a con-
 19 tract with a not-for-profit organization that operates inde-
 20 pendent of group health plans and health insurance
 21 issuers. Such Ombudsman shall be responsible for at least
 22 the following:

23 (1) To assist consumers in the State in choos-
 24 ing among health insurance coverage or among cov-
 25 erage options offered within group health plans.

1 (2) To provide counseling and assistance to en-
2 rollees dissatisfied with their treatment by health in-
3 surance issuers and group health plans in regard to
4 such coverage or plans and with respect to griev-
5 ances and appeals regarding determinations under
6 such coverage or plans.

7 (b) FEDERAL ROLE.—In the case of any State that
8 does not provide for such an Ombudsman under sub-
9 section (a), the Secretary shall provide for the creation
10 and operation of a Health Insurance Ombudsman through
11 a contract with a not-for-profit organization that operates
12 independent of group health plans and health insurance
13 issuers and that is responsible for carrying out with re-
14 spect to that State the functions otherwise provided under
15 subsection (a) by a Health Insurance Ombudsman.

16 (c) AUTHORIZATION OF APPROPRIATIONS.—There
17 are authorized to be appropriated to the Secretary of
18 Health and Human Services such amounts as may be nec-
19 essary to provide for grants to States for contracts for
20 Health Insurance Ombudsmen under subsection (a) or
21 contracts for such Ombudsmen under subsection (b).

22 (d) CONSTRUCTION.—Nothing in this section shall be
23 construed to prevent the use of other forms of enrollee
24 assistance.

1 **CHAPTER 4—GRIEVANCE AND APPEALS**
2 **PROCEDURES**

3 **SEC. 131. ESTABLISHMENT OF GRIEVANCE PROCESS.**

4 (a) ESTABLISHMENT OF GRIEVANCE SYSTEM.—

5 (1) IN GENERAL.—A group health plan, and a
6 health insurance issuer in connection with the provi-
7 sion of health insurance coverage, shall establish and
8 maintain a system to provide for the presentation
9 and resolution of oral and written grievances
10 brought by individuals who are participants, bene-
11 ficiaries, or enrollees, or health care providers or
12 other individuals acting on behalf of an individual
13 and with the individual's consent, regarding any as-
14 pect of the plan's or issuer's services.

15 (2) SCOPE.—The system shall include griev-
16 ances regarding access to and availability of services,
17 quality of care, choice and accessibility of providers,
18 network adequacy, and compliance with the require-
19 ments of this subtitle.

20 (b) GRIEVANCE SYSTEM.—Such system shall include
21 the following components with respect to individuals who
22 are participants, beneficiaries, or enrollees:

23 (1) Written notification to all such individuals
24 and providers of the telephone numbers and business

1 addresses of the plan or issuer personnel responsible
2 for resolution of grievances and appeals.

3 (2) A system to record and document, over a
4 period of at least 3 previous years, all grievances
5 and appeals made and their status.

6 (3) A process providing for timely processing
7 and resolution of grievances.

8 (4) Procedures for follow-up action, including
9 the methods to inform the person making the grievance
10 of the resolution of the grievance.

11 (5) Notification to the continuous quality improvement
12 program under section 111(a) of all
13 grievances and appeals relating to quality of care.

14 **SEC. 132. INTERNAL APPEALS OF ADVERSE DETERMINA-**
15 **TIONS.**

16 (a) RIGHT OF APPEAL.—

17 (1) IN GENERAL.—A participant or beneficiary
18 in a group health plan, and an enrollee in health insurance
19 coverage offered by a health insurance
20 issuer, and any provider or other person acting on
21 behalf of such an individual with the individual's
22 consent, may appeal any appealable decision (as defined
23 in paragraph (2)) under the procedures described in this
24 section and (to the extent applicable)
25 section 133. Such individuals and providers shall be

1 provided with a written explanation of the appeal
2 process and the determination upon the conclusion
3 of the appeals process and as provided in section
4 121(b)(8).

5 (2) APPEALABLE DECISION DEFINED.—In this
6 section, the term “appealable decision” means any of
7 the following:

8 (A) Denial, reduction, or termination of, or
9 failure to provide or make payment (in whole or
10 in part) for, a benefit, including a failure to
11 cover an item or service for which benefits are
12 otherwise provided because it is determined to
13 be experimental or investigational or not medi-
14 cally necessary or appropriate.

15 (B) Failure to provide coverage of emer-
16 gency services or reimbursement of mainte-
17 nance care or post-stabilization care under sec-
18 tion 101.

19 (C) Failure to provide a choice of provider
20 under section 103.

21 (D) Failure to provide qualified health care
22 providers under section 103.

23 (E) Failure to provide access to specialty
24 and other care under section 104.

1 (F) Failure to provide continuation of care
2 under section 105.

3 (G) Failure to provide coverage of routine
4 patient costs in connection with an approval
5 clinical trial under section 106.

6 (H) Failure to provide access to needed
7 drugs under section 107(a)(3) or 107(b).

8 (I) Discrimination in delivery of services in
9 violation of section 109.

10 (J) An adverse determination under a utili-
11 zation review program under section 115.

12 (K) The imposition of a limitation that is
13 prohibited under section 151.

14 (b) INTERNAL APPEAL PROCESS.—

15 (1) IN GENERAL.—Each group health plan and
16 health insurance issuer shall establish and maintain
17 an internal appeal process under which any partici-
18 pant, beneficiary, enrollee, or provider acting on be-
19 half of such an individual with the individual's con-
20 sent, who is dissatisfied with any appealable decision
21 has the opportunity to appeal the decision through
22 an internal appeal process. The appeal may be com-
23 municated orally.

24 (2) CONDUCT OF REVIEW.—

1 (A) IN GENERAL.—The process shall in-
2 clude a review of the decision by a physician or
3 other health care professional (or professionals)
4 who has been selected by the plan or issuer and
5 who has not been involved in the appealable de-
6 cision at issue in the appeal.

7 (B) AVAILABILITY AND PARTICIPATION OF
8 CLINICAL PEERS.—The individuals conducting
9 such review shall include one or more clinical
10 peers (as defined in section 191(c)(2)) who have
11 not been involved in the appealable decision at
12 issue in the appeal.

13 (3) DEADLINE.—

14 (A) IN GENERAL.—Subject to subsection
15 (c), the plan or issuer shall conclude each ap-
16 peal as soon as possible after the time of the re-
17 ceipt of the appeal in accordance with medical
18 exigencies of the case involved, but in no event
19 later than—

20 (i) 72 hours after the time of receipt
21 of an expedited appeal, and

22 (ii) except as provided in subpara-
23 graph (B), 30 business days after such
24 time (or, if the participant, beneficiary, or
25 enrollee supplies additional information

1 that was not available to the plan or issuer
2 at the time of the receipt of the appeal,
3 after the date of supplying such additional
4 information) in the case of all other ap-
5 peals.

6 (B) EXTENSION.—In the case of an appeal
7 that does not relate to a decision regarding an
8 expedited appeal and that does not involve med-
9 ical exigencies, if a group health plan or health
10 insurance issuer is unable to conclude the ap-
11 peal within the time period provided under sub-
12 paragraph (A)(ii) due to circumstances beyond
13 the control of the plan or issuer, the deadline
14 shall be extended for up to an additional 10
15 business days if the plan or issuer provides, on
16 or before 10 days before the deadline otherwise
17 applicable, written notice to the participant,
18 beneficiary, or enrollee and the provider in-
19 volved of the extension and the reasons for the
20 extension.

21 (4) NOTICE.—If a plan or issuer denies an ap-
22 peal, the plan or issuer shall provide the participant,
23 beneficiary, or enrollee and provider involved with
24 notice in printed form of the denial and the reasons

1 therefore, together with a notice in printed form of
2 rights to any further appeal.

3 (c) EXPEDITED REVIEW PROCESS.—

4 (1) IN GENERAL.—A group health plan, and a
5 health insurance issuer, shall establish procedures in
6 writing for the expedited consideration of appeals
7 under subsection (b) in situations in which the appli-
8 cation of the normal timeframe for making a deter-
9 mination could seriously jeopardize the life or health
10 of the participant, beneficiary, or enrollee or such an
11 individual's ability to regain maximum function.

12 (2) PROCESS.—Under such procedures—

13 (A) the request for expedited appeal may
14 be submitted orally or in writing by an individ-
15 ual or provider who is otherwise entitled to re-
16 quest the appeal;

17 (B) all necessary information, including
18 the plan's or issuer's decision, shall be trans-
19 mitted between the plan or issuer and the re-
20 quester by telephone, facsimile, or other simi-
21 larly expeditious available method; and

22 (C) the plan or issuer shall expedite the
23 appeal if the request for an expedited appeal is
24 submitted under subparagraph (A) by a physi-

1 cian and the request indicates that the situation
2 described in paragraph (1) exists.

3 (d) DIRECT USE OF FURTHER APPEALS.—In the
4 event that the plan or issuer fails to comply with any of
5 the deadlines for completion of appeals under this section
6 or in the event that the plan or issuer for any reason ex-
7 pressly waives its rights to an internal review of an appeal
8 under subsection (b), the participant, beneficiary, or en-
9 rollee involved and the provider involved shall be relieved
10 of any obligation to complete the appeal involved and may,
11 at such an individual's or provider's option, proceed di-
12 rectly to seek further appeal through any applicable exter-
13 nal appeals process.

14 **SEC. 133. EXTERNAL APPEALS OF ADVERSE DETERMINA-**
15 **TIONS.**

16 (a) RIGHT TO EXTERNAL APPEAL.—

17 (1) IN GENERAL.—A group health plan, and a
18 health insurance issuer offering group health insur-
19 ance coverage, shall provide for an external appeals
20 process that meets the requirements of this section
21 in the case of an externally appealable decision de-
22 scribed in paragraph (2). The appropriate Secretary
23 shall establish standards to carry out such require-
24 ments.

1 (2) EXTERNALLY APPEALABLE DECISION DE-
 2 FINED.—For purposes of this section, the term “ex-
 3 ternally appealable decision” means an appealable
 4 decision (as defined in section 132(a)(2)) if—

5 (A) the amount involved exceeds a signifi-
 6 cant threshold; or

7 (B) the patient’s life or health (including,
 8 in the case of children, development) is jeopard-
 9 ized as a consequence of the decision.

10 Such term does not include a denial of coverage for
 11 services that are specifically listed in plan or cov-
 12 erage documents as excluded from coverage.

13 (3) EXHAUSTION OF INTERNAL APPEALS PROC-
 14 ESS.—A plan or issuer may condition the use of an
 15 external appeal process in the case of an externally
 16 appealable decision upon completion of the internal
 17 review process provided under section 132, but only
 18 if the decision is made in a timely basis consistent
 19 with the deadlines provided under this chapter.

20 (b) GENERAL ELEMENTS OF EXTERNAL APPEALS
 21 PROCESS.—

22 (1) CONTRACT WITH QUALIFIED EXTERNAL AP-
 23 PEAL ENTITY.—

24 (A) CONTRACT REQUIREMENT.—Subject to
 25 subparagraph (B), the external appeal process

1 under this section of a plan or issuer shall be
2 conducted under a contract between the plan or
3 issuer and one or more qualified external appeal
4 entities (as defined in subsection (c)).

5 (B) RESTRICTIONS ON QUALIFIED EXTER-
6 NAL APPEAL ENTITY.—

7 (i) BY STATE FOR HEALTH INSUR-
8 ANCE ISSUERS.—With respect to health in-
9 surance issuers in a State, the State may
10 provide for external review activities to be
11 conducted by a qualified external appeal
12 entity that is designated by the State or
13 that is selected by the State in such a
14 manner as to assure an unbiased deter-
15 mination.

16 (ii) BY FEDERAL GOVERNMENT FOR
17 GROUP HEALTH PLANS.—With respect to
18 group health plans, the appropriate Sec-
19 retary may exercise the same authority as
20 a State may exercise with respect to health
21 insurance issuers under clause (i). Such
22 authority may include requiring the use of
23 the qualified external appeal entity des-
24 ignated or selected under such clause.

1 (iii) LIMITATION ON PLAN OR ISSUER
2 SELECTION.—If an applicable authority
3 permits more than one entity to qualify as
4 a qualified external appeal entity with re-
5 spect to a group health plan or health in-
6 surance issuer and the plan or issuer may
7 select among such qualified entities, the
8 applicable authority—

9 (I) shall assure that the selection
10 process will not create any incentives
11 for external appeal entities to make a
12 decision in a biased manner, and

13 (II) shall implement a procedures
14 for auditing a sample of decisions by
15 such entities to assure that no such
16 decisions are made in a biased man-
17 ner.

18 (C) OTHER TERMS AND CONDITIONS.—
19 The terms and conditions of a contract under
20 this paragraph shall be consistent with the
21 standards the appropriate Secretary shall estab-
22 lish to assure there is no real or apparent con-
23 flict of interest in the conduct of external ap-
24 peal activities. Such contract shall provide that
25 the direct costs of the process (not including

1 costs of representation of a participant, bene-
 2 ficiary, or enrollee) shall be paid by the plan or
 3 issuer, and not by the participant, beneficiary,
 4 or enrollee.

5 (2) ELEMENTS OF PROCESS.—An external ap-
 6 peal process shall be conducted consistent with
 7 standards established by the appropriate Secretary
 8 that include at least the following:

9 (A) FAIR PROCESS; DE NOVO DETERMINA-
 10 TION.—The process shall provide for a fair, de
 11 novo determination.

12 (B) DETERMINATION CONCERNING EXTER-
 13 NALLY APPEALABLE DECISIONS.—A qualified
 14 external appeal entity shall determine whether a
 15 decision is an externally appealable decision and
 16 related decisions, including—

17 (i) whether such a decision involves an
 18 expedited appeal;

19 (ii) the appropriate deadlines for in-
 20 ternal review process required due to medi-
 21 cal exigencies in a case; and

22 (iii) whether such a process has been
 23 completed.

24 (C) OPPORTUNITY TO SUBMIT EVIDENCE,
 25 HAVE REPRESENTATION, AND MAKE ORAL

1 PRESENTATION.—Each party to an externally
2 appealable decision—

3 (i) may submit and review evidence
4 related to the issues in dispute,

5 (ii) may use the assistance or rep-
6 resentation of one or more individuals (any
7 of whom may be an attorney), and

8 (iii) may make an oral presentation.

9 (D) PROVISION OF INFORMATION.—The
10 plan or issuer involved shall provide timely ac-
11 cess to all its records relating to the matter of
12 the externally appealable decision and to all
13 provisions of the plan or health insurance cov-
14 erage (including any coverage manual) relating
15 to the matter.

16 (E) TIMELY DECISIONS.—A determination
17 by the external appeal entity on the decision
18 shall—

19 (i) be made orally or in writing and,
20 if it is made orally, shall be supplied to the
21 parties in writing as soon as possible;

22 (ii) be binding on the plan or issuer;

23 (iii) be made in accordance with the
24 medical exigencies of the case involved, but
25 in no event later than 60 days (or 72

1 hours in the case of an expedited appeal)
 2 from the date of completion of the filing
 3 of notice of external appeal of the decision;

4 (iv) state, in layperson’s language, the
 5 basis for the determination, including, if
 6 relevant, any basis in the terms or condi-
 7 tions of the plan or coverage; and

8 (v) inform the participant, beneficiary,
 9 or enrollee of the individual’s rights to seek
 10 further review by the courts (or other proc-
 11 ess) of the external appeal determination.

12 (c) QUALIFICATIONS OF EXTERNAL APPEAL ENTI-
 13 TIES.—

14 (1) IN GENERAL.—For purposes of this section,
 15 the term “qualified external appeal entity” means,
 16 in relation to a plan or issuer, an entity (which may
 17 be a governmental entity) that is certified under
 18 paragraph (2) as meeting the following require-
 19 ments:

20 (A) There is no real or apparent conflict of
 21 interest that would impede the entity conduct-
 22 ing external appeal activities independent of the
 23 plan or issuer.

24 (B) The entity conducts external appeal
 25 activities through clinical peers.

1 (C) The entity has sufficient medical, legal,
2 and other expertise and sufficient staffing to
3 conduct external appeal activities for the plan
4 or issuer on a timely basis consistent with sub-
5 section (b)(3)(E).

6 (D) The entity meets such other require-
7 ments as the appropriate Secretary may im-
8 pose.

9 (2) CERTIFICATION OF EXTERNAL APPEAL EN-
10 TITIES.—

11 (A) IN GENERAL.—In order to be treated
12 as a qualified external appeal entity with re-
13 spect to—

14 (i) a group health plan, the entity
15 must be certified (and, in accordance with
16 subparagraph (B), periodically recertified)
17 as meeting the requirements of paragraph
18 (1) by the Secretary of Labor (or under a
19 process recognized or approved by the Sec-
20 retary of Labor); or

21 (ii) a health insurance issuer operat-
22 ing in a State, the entity must be certified
23 (and, in accordance with subparagraph
24 (B), periodically recertified) as meeting
25 such requirements by the applicable State

1 authority (or, if the States has not estab-
2 lished an adequate certification and recer-
3 tification process, by the Secretary of
4 Health and Human Services, or under a
5 process recognized or approved by such
6 Secretary).

7 (B) RECERTIFICATION PROCESS.—The ap-
8 propriate Secretary shall develop standards for
9 the recertification of external appeal entities.
10 Such standards shall include a specification
11 of—

12 (i) the information required to be sub-
13 mitted as a condition of recertification on
14 the entity's performance of external appeal
15 activities, which information shall include
16 the number of cases reviewed, a summary
17 of the disposition of those cases, the length
18 of time in making determinations on those
19 cases, and such information as may be nec-
20 essary to assure the independence of the
21 entity from the plans or issuers for which
22 external appeal activities are being con-
23 ducted; and

24 (ii) the periodicity which recertifi-
25 cation will be required.

1 (d) CONTINUING LEGAL RIGHTS OF ENROLLEES.—
2 Nothing in this subtitle shall be construed as removing
3 any legal rights of participants, beneficiaries, enrollees,
4 and others under State or Federal law, including the right
5 to file judicial actions to enforce rights.

6 **CHAPTER 5—PROTECTING THE DOCTOR-**
7 **PATIENT RELATIONSHIP**

8 **SEC. 141. PROHIBITION OF INTERFERENCE WITH CERTAIN**
9 **MEDICAL COMMUNICATIONS.**

10 (a) PROHIBITION.—

11 (1) GENERAL RULE.—The provisions of any
12 contract or agreement, or the operation of any con-
13 tract or agreement, between a group health plan or
14 health insurance issuer in relation to health insur-
15 ance coverage (including any partnership, associa-
16 tion, or other organization that enters into or ad-
17 ministers such a contract or agreement) and a
18 health care provider (or group of health care provid-
19 ers) shall not prohibit or restrict the provider from
20 engaging in medical communications with the pro-
21 vider's patient.

22 (2) NULLIFICATION.—Any contract provision or
23 agreement that restricts or prohibits medical com-
24 munications in violation of paragraph (1) shall be
25 null and void.

1 (b) RULES OF CONSTRUCTION.—Nothing in this sec-
2 tion shall be construed—

3 (1) to prohibit the enforcement, as part of a
4 contract or agreement to which a health care pro-
5 vider is a party, of any mutually agreed upon terms
6 and conditions, including terms and conditions re-
7 quiring a health care provider to participate in, and
8 cooperate with, all programs, policies, and proce-
9 dures developed or operated by a group health plan
10 or health insurance issuer to assure, review, or im-
11 prove the quality and effective utilization of health
12 care services (if such utilization is according to
13 guidelines or protocols that are based on clinical or
14 scientific evidence and the professional judgment of
15 the provider) but only if the guidelines or protocols
16 under such utilization do not prohibit or restrict
17 medical communications between providers and their
18 patients; or

19 (2) to permit a health care provider to mis-
20 represent the scope of benefits covered under the
21 group health plan or health insurance coverage or to
22 otherwise require a group health plan health insur-
23 ance issuer to reimburse providers for benefits not
24 covered under the plan or coverage.

1 (c) MEDICAL COMMUNICATION DEFINED.—In this
2 section:

3 (1) IN GENERAL.—The term “medical commu-
4 nication” means any communication made by a
5 health care provider with a patient of the health care
6 provider (or the guardian or legal representative of
7 such patient) with respect to—

8 (A) the patient’s health status, medical
9 care, or treatment options;

10 (B) any utilization review requirements
11 that may affect treatment options for the pa-
12 tient; or

13 (C) any financial incentives that may af-
14 fect the treatment of the patient.

15 (2) MISREPRESENTATION.—The term “medical
16 communication” does not include a communication
17 by a health care provider with a patient of the
18 health care provider (or the guardian or legal rep-
19 resentative of such patient) if the communication in-
20 volves a knowing or willful misrepresentation by
21 such provider.

1 **SEC. 142. PROHIBITION AGAINST TRANSFER OF INDEM-**
2 **NIFICATION OR IMPROPER INCENTIVE AR-**
3 **RANGEMENTS.**

4 (a) PROHIBITION OF TRANSFER OF INDEMNIFICA-
5 TION.—

6 (1) IN GENERAL.—No contract or agreement
7 between a group health plan or health insurance
8 issuer (or any agent acting on behalf of such a plan
9 or issuer) and a health care provider shall contain
10 any provision purporting to transfer to the health
11 care provider by indemnification or otherwise any li-
12 ability relating to activities, actions, or omissions of
13 the plan, issuer, or agent (as opposed to the pro-
14 vider).

15 (2) NULLIFICATION.—Any contract or agree-
16 ment provision described in paragraph (1) shall be
17 null and void.

18 (b) PROHIBITION OF IMPROPER PHYSICIAN INCEN-
19 TIVE PLANS.—

20 (1) IN GENERAL.—A group health plan and a
21 health insurance issuer offering health insurance
22 coverage may not operate any physician incentive
23 plan (as defined in subparagraph (B) of section
24 1876(i)(8) of the Social Security Act) unless the re-
25 quirements described in subparagraph (A) of such
26 section are met with respect to such a plan.

1 (2) APPLICATION.—For purposes of carrying
2 out paragraph (1), any reference in section
3 1876(i)(8) of the Social Security Act to the Sec-
4 retary, an eligible organization, or an individual en-
5 rolled with the organization shall be treated as a ref-
6 erence to the applicable authority, a group health
7 plan or health insurance issuer, respectively, and a
8 participant, beneficiary, or enrollee with the plan or
9 organization, respectively.

10 **SEC. 143. ADDITIONAL RULES REGARDING PARTICIPATION**
11 **OF HEALTH CARE PROFESSIONALS.**

12 (a) PROCEDURES.—Insofar as a group health plan,
13 or health insurance issuer that offers health insurance cov-
14 erage, provides benefits through participating health care
15 professionals, the plan or issuer shall establish reasonable
16 procedures relating to the participation (under an agree-
17 ment between a professional and the plan or issuer) of
18 such professionals under the plan or coverage. Such proce-
19 dures shall include—

20 (1) providing notice of the rules regarding par-
21 ticipation;

22 (2) providing written notice of participation de-
23 cisions that are adverse to professionals; and

24 (3) providing a process within the plan or issuer
25 for appealing such adverse decisions, including the

1 presentation of information and views of the profes-
 2 sional regarding such decision.

3 (b) CONSULTATION IN MEDICAL POLICIES.—A group
 4 health plan, and health insurance issuer that offers health
 5 insurance coverage, shall consult with participating physi-
 6 cians (if any) regarding the plan’s or issuer’s medical pol-
 7 icy, quality, and medical management procedures.

8 **SEC. 144. PROTECTION FOR PATIENT ADVOCACY.**

9 (a) PROTECTION FOR USE OF UTILIZATION REVIEW
 10 AND GRIEVANCE PROCESS.—A group health plan, and a
 11 health insurance issuer with respect to the provision of
 12 health insurance coverage, may not retaliate against a par-
 13 ticipant, beneficiary, enrollee, or health care provider
 14 based on the participant’s, beneficiary’s, enrollee’s or pro-
 15 vider’s use of, or participation in, a utilization review proc-
 16 ess or a grievance process of the plan or issuer (including
 17 an internal or external review or appeal process) under
 18 this subtitle.

19 (b) PROTECTION FOR QUALITY ADVOCACY BY
 20 HEALTH CARE PROFESSIONALS.—

21 (1) IN GENERAL.—A group health plan or
 22 health insurance issuer may not retaliate or dis-
 23 criminate against a protected health care profes-
 24 sional because the professional in good faith—

1 (A) discloses information relating to the
2 care, services, or conditions affecting one or
3 more participants, beneficiaries, or enrollees of
4 the plan or issuer to an appropriate public reg-
5 ulatory agency, an appropriate private accredi-
6 tation body, or appropriate management per-
7 sonnel of the plan or issuer; or

8 (B) initiates, cooperates, or otherwise par-
9 ticipates in an investigation or proceeding by
10 such an agency with respect to such care, serv-
11 ices, or conditions.

12 If an institutional health care provider is a partici-
13 pating provider with such a plan or issuer or other-
14 wise receives payments for benefits provided by such
15 a plan or issuer, the provisions of the previous sen-
16 tence shall apply to the provider in relation to care,
17 services, or conditions affecting one or more patients
18 within an institutional health care provider in the
19 same manner as they apply to the plan or issuer in
20 relation to care, services, or conditions provided to
21 one or more participants, beneficiaries, or enrollees;
22 and for purposes of applying this sentence, any ref-
23 erence to a plan or issuer is deemed a reference to
24 the institutional health care provider.

1 (2) GOOD FAITH ACTION.—For purposes of
2 paragraph (1), a protected health care professional
3 is considered to be acting in good faith with respect
4 to disclosure of information or participation if, with
5 respect to the information disclosed as part of the
6 action—

7 (A) the disclosure is made on the basis of
8 personal knowledge and is consistent with that
9 degree of learning and skill ordinarily possessed
10 by health care professionals with the same li-
11 censure or certification and the same experi-
12 ence;

13 (B) the professional reasonably believes the
14 information to be true;

15 (C) the information evidences either a vio-
16 lation of a law, rule, or regulation, of an appli-
17 cable accreditation standard, or of a generally
18 recognized professional or clinical standard or
19 that a patient is in imminent hazard of loss of
20 life or serious injury; and

21 (D) subject to subparagraphs (B) and (C)
22 of paragraph (3), the professional has followed
23 reasonable internal procedures of the plan,
24 issuer, or institutional health care provider es-

1 tablished or the purpose of addressing quality
2 concerns before making the disclosure.

3 (3) EXCEPTION AND SPECIAL RULE.—

4 (A) GENERAL EXCEPTION.—Paragraph (1)
5 does not protect disclosures that would violate
6 Federal or State law or diminish or impair the
7 rights of any person to the continued protection
8 of confidentiality of communications provided
9 by such law.

10 (B) NOTICE OF INTERNAL PROCEDURES.—
11 Subparagraph (D) of paragraph (2) shall not
12 apply unless the internal procedures involved
13 are reasonably expected to be known to the
14 health care professional involved. For purposes
15 of this subparagraph, a health care professional
16 is reasonably expected to know of internal pro-
17 cedures if those procedures have been made
18 available to the professional through distribu-
19 tion or posting.

20 (C) INTERNAL PROCEDURE EXCEPTION.—
21 Subparagraph (D) of paragraph (2) also shall
22 not apply if—

- 23 (i) the disclosure relates to an immi-
24 nent hazard of loss of life or serious injury
25 to a patient;

1 (ii) the disclosure is made to an ap-
2 propriate private accreditation body pursu-
3 ant to disclosure procedures established by
4 the body; or

5 (iii) the disclosure is in response to an
6 inquiry made in an investigation or pro-
7 ceeding of an appropriate public regulatory
8 agency and the information disclosed is
9 limited to the scope of the investigation or
10 proceeding.

11 (4) ADDITIONAL CONSIDERATIONS.—It shall
12 not be a violation of paragraph (1) to take an ad-
13 verse action against a protected health care profes-
14 sional if the plan, issuer, or provider taking the ad-
15 verse action involved demonstrates that it would
16 have taken the same adverse action even in the ab-
17 sence of the activities protected under such para-
18 graph.

19 (5) NOTICE.—A group health plan, health in-
20 surance issuer, and institutional health care provider
21 shall post a notice, to be provided or approved by
22 the Secretary of Labor, setting forth excerpts from,
23 or summaries of, the pertinent provisions of this
24 subsection and information pertaining to enforce-
25 ment of such provisions.

1 (6) CONSTRUCTIONS.—

2 (A) DETERMINATIONS OF COVERAGE.—

3 Nothing in this subsection shall be construed to
4 prohibit a plan or issuer from making a deter-
5 mination not to pay for a particular medical
6 treatment or service or the services of a type of
7 health care professional.

8 (B) ENFORCEMENT OF PEER REVIEW PRO-
9 TOCOLS AND INTERNAL PROCEDURES.—Noth-
10 ing in this subsection shall be construed to pro-
11 hibit a plan, issuer, or provider from establish-
12 ing and enforcing reasonable peer review or uti-
13 lization review protocols or determining whether
14 a protected health care professional has com-
15 plied with those protocols or from establishing
16 and enforcing internal procedures for the pur-
17 pose of addressing quality concerns.

18 (C) RELATION TO OTHER RIGHTS.—Noth-
19 ing in this subsection shall be construed to
20 abridge rights of participants, beneficiaries, en-
21 rollees, and protected health care professionals
22 under other applicable Federal or State laws.

23 (7) PROTECTED HEALTH CARE PROFESSIONAL
24 DEFINED.—For purposes of this subsection, the
25 term “protected health care professional” means an

1 individual who is a licensed or certified health care
 2 professional and who—

3 (A) with respect to a group health plan or
 4 health insurance issuer, is an employee of the
 5 plan or issuer or has a contract with the plan
 6 or issuer for provision of services for which ben-
 7 efits are available under the plan or issuer; or

8 (B) with respect to an institutional health
 9 care provider, is an employee of the provider or
 10 has a contract or other arrangement with the
 11 provider respecting the provision of health care
 12 services.

13 **CHAPTER 6—PROMOTING GOOD MEDICAL** 14 **PRACTICE**

15 **SEC. 151. PROMOTING GOOD MEDICAL PRACTICE.**

16 (a) PROHIBITING ARBITRARY LIMITATIONS OR CON-
 17 DITIONS FOR THE PROVISION OF SERVICES.—

18 (1) IN GENERAL.—A group health plan, and a
 19 health insurance issuer in connection with the provi-
 20 sion of health insurance coverage, may not arbitrar-
 21 ily interfere with or alter the decision of the treating
 22 physician regarding the manner or setting in which
 23 particular services are delivered if the services are
 24 medically necessary or appropriate for treatment or

1 diagnosis to the extent that such treatment or diag-
 2 nosis is otherwise a covered benefit.

3 (2) CONSTRUCTION.—Paragraph (1) shall not
 4 be construed as prohibiting a plan or issuer from
 5 limiting the delivery of services to one or more
 6 health care providers within a network of such pro-
 7 viders.

8 (3) MANNER OR SETTING DEFINED.—In para-
 9 graph (1), the term “manner or setting” means the
 10 location of treatment, such as whether treatment is
 11 provided on an inpatient or outpatient basis, and the
 12 duration of treatment, such as the number of days
 13 in a hospital, such term does not include the cov-
 14 erage of a particular service or treatment.

15 (b) NO CHANGE IN COVERAGE.—Subsection (a) shall
 16 not be construed as requiring coverage of particular serv-
 17 ices the coverage of which is otherwise not covered under
 18 the terms of the plan or coverage or from conducting utili-
 19 zation review activities consistent with this subsection.

20 (c) MEDICAL NECESSITY OR APPROPRIATENESS DE-
 21 FINED.—In subsection (a), the term “medically necessary
 22 or appropriate” means, with respect to a service or benefit,
 23 a service or benefit which is consistent with generally ac-
 24 cepted principles of professional medical practice.

1 **SEC. 152. STANDARDS RELATING TO BENEFITS FOR CER-**
2 **TAIN BREAST CANCER TREATMENT.**

3 (a) INPATIENT CARE.—

4 (1) IN GENERAL.—A group health plan, and a
5 health insurance issuer offering group health insur-
6 ance coverage, that provides medical and surgical
7 benefits shall ensure that inpatient coverage with re-
8 spect to the treatment of breast cancer is provided
9 for a period of time as is determined by the attend-
10 ing physician, in his or her professional judgment
11 consistent with generally accepted medical stand-
12 ards, in consultation with the patient, to be medi-
13 cally appropriate following—

14 (A) a mastectomy;

15 (B) a lumpectomy; or

16 (C) a lymph node dissection for the treat-
17 ment of breast cancer.

18 (2) EXCEPTION.—Nothing in this section shall
19 be construed as requiring the provision of inpatient
20 coverage if the attending physician and patient de-
21 termine that a shorter period of hospital stay is
22 medically appropriate.

23 (b) PROHIBITIONS.—A group health plan, and a
24 health insurance issuer offering group health insurance
25 coverage in connection with a group health plan, may
26 not—

1 (1) deny to a woman eligibility, or continued
 2 eligibility, to enroll or to renew coverage under the
 3 terms of the plan, solely for the purpose of avoiding
 4 the requirements of this section;

5 (2) provide monetary payments or rebates to
 6 women to encourage such women to accept less than
 7 the minimum protections available under this sec-
 8 tion;

9 (3) penalize or otherwise reduce or limit the re-
 10 imbursement of an attending provider because such
 11 provider provided care to an individual participant
 12 or beneficiary in accordance with this section;

13 (4) provide incentives (monetary or otherwise)
 14 to an attending provider to induce such provider to
 15 provide care to an individual participant or bene-
 16 ficiary in a manner inconsistent with this section; or

17 (5) subject to subsection (c)(3), restrict benefits
 18 for any portion of a period within a hospital length
 19 of stay required under subsection (a) in a manner
 20 which is less favorable than the benefits provided for
 21 any preceding portion of such stay.

22 (c) RULES OF CONSTRUCTION.—

23 (1) Nothing in this section shall be construed to
 24 require a woman who is a participant or bene-
 25 ficiary—

1 (A) to undergo a mastectomy or lymph
2 node dissection in a hospital; or

3 (B) to stay in the hospital for a fixed pe-
4 riod of time following a mastectomy or lymph
5 node dissection.

6 (2) This section shall not apply with respect to
7 any group health plan, or any group health insur-
8 ance coverage offered by a health insurance issuer,
9 which does not provide benefits for hospital lengths
10 of stay in connection with a mastectomy or lymph
11 node dissection for the treatment of breast cancer.

12 (3) Nothing in this section shall be construed as
13 preventing a group health plan or issuer from impos-
14 ing deductibles, coinsurance, or other cost-sharing in
15 relation to benefits for hospital lengths of stay in
16 connection with a mastectomy or lymph node dissec-
17 tion for the treatment of breast cancer under the
18 plan (or under health insurance coverage offered in
19 connection with a group health plan), except that
20 such coinsurance or other cost-sharing for any por-
21 tion of a period within a hospital length of stay re-
22 quired under subsection (a) may not be greater than
23 such coinsurance or cost-sharing for any preceding
24 portion of such stay.

1 (d) LEVEL AND TYPE OF REIMBURSEMENTS.—Noth-
 2 ing in this section shall be construed to prevent a group
 3 health plan or a health insurance issuer offering group
 4 health insurance coverage from negotiating the level and
 5 type of reimbursement with a provider for care provided
 6 in accordance with this section.

7 (e) EXCEPTION FOR HEALTH INSURANCE COVERAGE
 8 IN CERTAIN STATES.—

9 (1) IN GENERAL.—The requirements of this
 10 section shall not apply with respect to health insur-
 11 ance coverage if there is a State law (as defined in
 12 section 2723(d)(1) of the Public Health Service Act)
 13 for a State that regulates such coverage that is de-
 14 scribed in any of the following subparagraphs:

15 (A) Such State law requires such coverage
 16 to provide for at least a 48-hour hospital length
 17 of stay following a mastectomy performed for
 18 treatment of breast cancer and at least a 24-
 19 hour hospital length of stay following a lymph
 20 node dissection for treatment of breast cancer.

21 (B) Such State law requires, in connection
 22 with such coverage for surgical treatment of
 23 breast cancer, that the hospital length of stay
 24 for such care is left to the decision of (or re-

1 quired to be made by) the attending provider in
2 consultation with the woman involved.

3 (2) CONSTRUCTION.—Section 2723(a)(1) of the
4 Public Health Service Act and section 731(a)(1) of
5 the Employee Retirement Income Security Act of
6 1974 shall not be construed as superseding a State
7 law described in paragraph (1).

8 **SEC. 153. STANDARDS RELATING TO BENEFITS FOR RECON-**
9 **STRUCTIVE BREAST SURGERY.**

10 (a) REQUIREMENTS FOR RECONSTRUCTIVE BREAST
11 SURGERY.—

12 (1) IN GENERAL.—A group health plan, and a
13 health insurance issuer offering group health insur-
14 ance coverage, that provides coverage for breast sur-
15 gery in connection with a mastectomy shall provide
16 coverage for reconstructive breast surgery resulting
17 from the mastectomy. Such coverage shall include
18 coverage for all stages of reconstructive breast sur-
19 gery performed on a nondiseased breast to establish
20 symmetry with the diseased when reconstruction on
21 the diseased breast is performed and coverage of
22 prostheses and complications of mastectomy includ-
23 ing lymphedema.

24 (2) RECONSTRUCTIVE BREAST SURGERY DE-
25 FINED.—In this section, the term “reconstructive

1 breast surgery” means surgery performed as a result
 2 of a mastectomy to reestablish symmetry between
 3 two breasts, and includes augmentation
 4 mammoplasty, reduction mammoplasty, and
 5 mastopexy.

6 (3) MASTECTOMY DEFINED.—In this section,
 7 the term “mastectomy” means the surgical removal
 8 of all or part of a breast.

9 (b) PROHIBITIONS.—

10 (1) DENIAL OF COVERAGE BASED ON COSMETIC
 11 SURGERY.—A group health plan, and a health insur-
 12 ance issuer offering group health insurance coverage
 13 in connection with a group health plan, may not
 14 deny coverage described in subsection (a)(1) on the
 15 basis that the coverage is for cosmetic surgery.

16 (2) APPLICATION OF SIMILAR PROHIBITIONS.—
 17 Paragraphs (2) through (5) of section 152 shall
 18 apply under this section in the same manner as they
 19 apply with respect to section 152.

20 (c) RULES OF CONSTRUCTION.—

21 (1) Nothing in this section shall be construed to
 22 require a woman who is a participant or beneficiary
 23 to undergo reconstructive breast surgery.

24 (2) This section shall not apply with respect to
 25 any group health plan, or any group health insur-

1 ance coverage offered by a health insurance issuer,
 2 which does not provide benefits for mastectomies.

3 (3) Nothing in this section shall be construed as
 4 preventing a group health plan or issuer from impos-
 5 ing deductibles, coinsurance, or other cost-sharing in
 6 relation to benefits for reconstructive breast surgery
 7 under the plan (or under health insurance coverage
 8 offered in connection with a group health plan), ex-
 9 cept that such coinsurance or other cost-sharing for
 10 any portion may not be greater than such coinsur-
 11 ance or cost-sharing that is otherwise applicable with
 12 respect to benefits for mastectomies.

13 (d) LEVEL AND TYPE OF REIMBURSEMENTS.—Noth-
 14 ing in this section shall be construed to prevent a group
 15 health plan or a health insurance issuer offering group
 16 health insurance coverage from negotiating the level and
 17 type of reimbursement with a provider for care provided
 18 in accordance with this section.

19 (e) EXCEPTION FOR HEALTH INSURANCE COVERAGE
 20 IN CERTAIN STATES.—

21 (1) IN GENERAL.—The requirements of this
 22 section shall not apply with respect to health insur-
 23 ance coverage if there is a State law (as defined in
 24 section 2723(d)(1) of the Public Health Service Act)
 25 for a State that regulates such coverage and that re-

1 quires coverage of at least the coverage of recon-
 2 structive breast surgery otherwise required under
 3 this section.

4 (2) CONSTRUCTION.—Section 2723(a)(1) of the
 5 Public Health Service Act and section 731(a)(1) of
 6 the Employee Retirement Income Security Act of
 7 1974 shall not be construed as superseding a State
 8 law described in paragraph (1).

9 **CHAPTER 7—DEFINITIONS**

10 **SEC. 191. DEFINITIONS.**

11 (a) INCORPORATION OF GENERAL DEFINITIONS.—
 12 The provisions of section 2971 of the Public Health Serv-
 13 ice Act shall apply for purposes of this subtitle in the same
 14 manner as they apply for purposes of title XXVII of such
 15 Act.

16 (b) SECRETARY.—Except as otherwise provided, the
 17 term “Secretary” means the Secretary of Health and
 18 Human Services, in consultation with the Secretary of
 19 Labor and the Secretary of the Treasury and the term
 20 “appropriate Secretary” means the Secretary of Health
 21 and Human Services in relation to carrying out this sub-
 22 title under sections 2706 and 2751 of the Public Health
 23 Service Act, the Secretary of Labor in relation to carrying
 24 out this subtitle under section 713 of the Employee Retire-
 25 ment Income Security Act of 1974, and the Secretary of

1 the Treasury in relation to carrying out this subtitle under
 2 chapter 100 and section 4980D of the Internal Revenue
 3 Code of 1986.

4 (c) ADDITIONAL DEFINITIONS.—For purposes of this
 5 subtitle:

6 (1) APPLICABLE AUTHORITY.—The term “ap-
 7 plicable authority” means—

8 (A) in the case of a group health plan, the
 9 Secretary of Health and Human Services and
 10 the Secretary of Labor; and

11 (B) in the case of a health insurance issuer
 12 with respect to a specific provision of this sub-
 13 title, the applicable State authority (as defined
 14 in section 2791(d) of the Public Health Service
 15 Act), or the Secretary of Health and Human
 16 Services, if such Secretary is enforcing such
 17 provision under section 2722(a)(2) or
 18 2761(a)(2) of the Public Health Service Act.

19 (2) CLINICAL PEER.—The term “clinical peer”
 20 means, with respect to a review or appeal, a physi-
 21 cian (allopathic or osteopathic) or other health care
 22 professional who holds a non-restricted license in a
 23 State and who is appropriately credentialed in the
 24 same or similar specialty as typically manages the
 25 medical condition, procedure, or treatment under re-

1 view or appeal and includes a pediatric specialist
2 where appropriate; except that only a physician may
3 be a clinical peer with respect to the review or ap-
4 peal of treatment rendered by a physician.

5 (3) HEALTH CARE PROVIDER.—The term
6 “health care provider” includes a physician or other
7 health care professional, as well as an institutional
8 provider of health care services.

9 (4) NONPARTICIPATING.—The term “non-
10 participating” means, with respect to a health care
11 provider that provides health care items and services
12 to a participant, beneficiary, or enrollee under group
13 health plan or health insurance coverage, a health
14 care provider that is not a participating health care
15 provider with respect to such items and services.

16 (5) PARTICIPATING.—The term “participating”
17 mean, with respect to a health care provider that
18 provides health care items and services to a partici-
19 pant, beneficiary, or enrollee under group health
20 plan or health insurance coverage offered by a
21 health insurance issuer, a health care provider that
22 furnishes such items and services under a contract
23 or other arrangement with the plan or issuer.

1 **SEC. 192. PREEMPTION; STATE FLEXIBILITY; CONSTRUC-**
 2 **TION.**

3 (a) CONTINUED APPLICABILITY OF STATE LAW
 4 WITH RESPECT TO HEALTH INSURANCE ISSUERS.—

5 (1) IN GENERAL.—Subject to paragraph (2),
 6 this subtitle shall not be construed to supersede any
 7 provision of State law which establishes, implements,
 8 or continues in effect any standard or requirement
 9 solely relating to health insurance issuers in connec-
 10 tion with group health insurance coverage except to
 11 the extent that such standard or requirement pre-
 12 vents the application of a requirement of this sub-
 13 title.

14 (2) CONTINUED PREEMPTION WITH RESPECT
 15 TO GROUP HEALTH PLANS.—Nothing in this subtitle
 16 shall be construed to affect or modify the provisions
 17 of section 514 of the Employee Retirement Income
 18 Security Act of 1974 with respect to group health
 19 plans.

20 (b) RULES OF CONSTRUCTION.—Except as provided
 21 in sections 152 and 153, nothing in this subtitle shall be
 22 construed as requiring a group health plan or health insur-
 23 ance coverage to provide specific benefits under the terms
 24 of such plan or coverage.

25 (c) DEFINITIONS.—For purposes of this section:

1 (1) STATE LAW.—The term “State law” in-
2 cludes all laws, decisions, rules, regulations, or other
3 State action having the effect of law, of any State.
4 A law of the United States applicable only to the
5 District of Columbia shall be treated as a State law
6 rather than a law of the United States.

7 (2) STATE.—The term “State” includes a
8 State, the Northern Mariana Islands, any political
9 subdivisions of a State or such Islands, or any agen-
10 cy or instrumentality of either.

11 **SEC. 193. REGULATIONS.**

12 The Secretaries of Health and Human Services,
13 Labor, and the Treasury shall issue such regulations as
14 may be necessary or appropriate to carry out this subtitle.
15 Such regulations shall be issued consistent with section
16 104 of Health Insurance Portability and Accountability
17 Act of 1996. Such Secretaries may promulgate any in-
18 terim final rules as the Secretaries determine are appro-
19 priate to carry out this subtitle.

1 **Subtitle B—Application of Patient**
 2 **Protection Standards to Group**
 3 **Health Plans and Health Insur-**
 4 **ance Coverage Under Public**
 5 **Health Service Act**

6 **SEC. 201. APPLICATION TO GROUP HEALTH PLANS AND**
 7 **GROUP HEALTH INSURANCE COVERAGE.**

8 (a) IN GENERAL.—Subpart 2 of part A of title
 9 XXVII of the Public Health Service Act is amended by
 10 adding at the end the following new section:

11 **“SEC. 2706. PATIENT PROTECTION STANDARDS.**

12 “(a) IN GENERAL.—Each group health plan shall
 13 comply with patient protection requirements under sub-
 14 title A of the Patients’ Bill of Rights Act of 1998, and
 15 each health insurance issuer shall comply with patient pro-
 16 tection requirements under such subtitle with respect to
 17 group health insurance coverage it offers, and such re-
 18 quirements shall be deemed to be incorporated into this
 19 subsection.

20 “(b) NOTICE.—A group health plan shall comply with
 21 the notice requirement under section 711(d) of the Em-
 22 ployee Retirement Income Security Act of 1974 with re-
 23 spect to the requirements referred to in subsection (a) and
 24 a health insurance issuer shall comply with such notice

1 requirement as if such section applied to such issuer and
 2 such issuer were a group health plan.”.

3 (b) CONFORMING AMENDMENT.—Section
 4 2721(b)(2)(A) of such Act (42 U.S.C. 300gg–21(b)(2)(A))
 5 is amended by inserting “(other than section 2706)” after
 6 “requirements of such subparts”.

7 **SEC. 202. APPLICATION TO INDIVIDUAL HEALTH INSUR-**
 8 **ANCE COVERAGE.**

9 Part B of title XXVII of the Public Health Service
 10 Act is amended by inserting after section 2751 the follow-
 11 ing new section:

12 **“SEC. 2752. PATIENT PROTECTION STANDARDS.**

13 “(a) IN GENERAL.—Each health insurance issuer
 14 shall comply with patient protection requirements under
 15 subtitle A of the Patients’ Bill of Rights Act of 1998 with
 16 respect to individual health insurance coverage it offers,
 17 and such requirements shall be deemed to be incorporated
 18 into this subsection.

19 “(b) NOTICE.—A health insurance issuer under this
 20 part shall comply with the notice requirement under sec-
 21 tion 711(d) of the Employee Retirement Income Security
 22 Act of 1974 with respect to the requirements of such sub-
 23 title as if such section applied to such issuer and such
 24 issuer were a group health plan.”.

1 **Subtitle C—Amendments to the**
 2 **Employee Retirement Income**
 3 **Security Act of 1974**

4 **SEC. 301. APPLICATION OF PATIENT PROTECTION STAND-**
 5 **ARDS TO GROUP HEALTH PLANS AND GROUP**
 6 **HEALTH INSURANCE COVERAGE UNDER THE**
 7 **EMPLOYEE RETIREMENT INCOME SECURITY**
 8 **ACT OF 1974.**

9 (a) IN GENERAL.—Subpart B of part 7 of subtitle
 10 B of title I of the Employee Retirement Income Security
 11 Act of 1974 is amended by adding at the end the following
 12 new section:

13 **“SEC. 713. PATIENT PROTECTION STANDARDS.**

14 “(a) IN GENERAL.—Subject to subsection (b), a
 15 group health plan (and a health insurance issuer offering
 16 group health insurance coverage in connection with such
 17 a plan) shall comply with the requirements of subtitle A
 18 of the Patients’ Bill of Rights Act of 1998 (as in effect
 19 as of the date of the enactment of such Act), and such
 20 requirements shall be deemed to be incorporated into this
 21 subsection.

22 “(b) PLAN SATISFACTION OF CERTAIN REQUIRE-
 23 MENTS.—

24 “(1) SATISFACTION OF CERTAIN REQUIRE-
 25 MENTS THROUGH INSURANCE.—For purposes of

1 subsection (a), insofar as a group health plan pro-
2 vides benefits in the form of health insurance cov-
3 erage through a health insurance issuer, the plan
4 shall be treated as meeting the following require-
5 ments of subtitle A of the Patients' Bill of Rights
6 Act of 1998 with respect to such benefits and not
7 be considered as failing to meet such requirements
8 because of a failure of the issuer to meet such re-
9 quirements so long as the plan sponsor or its rep-
10 resentatives did not cause such failure by the issuer:

11 “(A) Section 101 (relating to access to
12 emergency care).

13 “(B) Section 102(a)(1) (relating to offer-
14 ing option to purchase point-of-service cov-
15 erage), but only insofar as the plan is meeting
16 such requirement through an agreement with
17 the issuer to offer the option to purchase point-
18 of-service coverage under such section.

19 “(C) Section 103 (relating to choice of pro-
20 viders).

21 “(D) Section 104 (relating to access to
22 specialty care).

23 “(E) Section 105(a)(1) (relating to con-
24 tinuity in case of termination of provider con-
25 tract) and section 105(a)(2) (relating to con-

1 continuity in case of termination of issuer con-
2 tract), but only insofar as a replacement issuer
3 assumes the obligation for continuity of care.

4 “(F) section 106 (relating to coverage for
5 individuals participating in approved clinical
6 trials.)

7 “(G) section 107 (relating to access to
8 needed prescription drugs).

9 “(H) Section 108 (relating to adequacy of
10 provider network).

11 “(I) Chapter 2 (relating to quality assur-
12 ance).

13 “(J) Section 143 (relating to additional
14 rules regarding participation of health care pro-
15 fessionals).

16 “(K) Section 152 (relating to standards re-
17 lating to benefits for certain breast cancer
18 treatment).

19 “(L) Section 153 (relating to standards re-
20 lating to benefits for reconstructive breast sur-
21 gery).

22 “(2) INFORMATION.—With respect to informa-
23 tion required to be provided or made available under
24 section 121, in the case of a group health plan that
25 provides benefits in the form of health insurance

1 coverage through a health insurance issuer, the Sec-
2 retary shall determine the circumstances under
3 which the plan is not required to provide or make
4 available the information (and is not liable for the
5 issuer's failure to provide or make available the in-
6 formation), if the issuer is obligated to provide and
7 make available (or provides and makes available)
8 such information.

9 “(3) GRIEVANCE AND INTERNAL APPEALS.—

10 With respect to the grievance system and internal
11 appeals process required to be established under sec-
12 tions 131 and 132, in the case of a group health
13 plan that provides benefits in the form of health in-
14 surance coverage through a health insurance issuer,
15 the Secretary shall determine the circumstances
16 under which the plan is not required to provide for
17 such system and process (and is not liable for the
18 issuer's failure to provide for such system and proc-
19 ess), if the issuer is obligated to provide for (and
20 provides for) such system and process.

21 “(4) EXTERNAL APPEALS.—Pursuant to rules
22 of the Secretary, insofar as a group health plan en-
23 ters into a contract with a qualified external appeal
24 entity for the conduct of external appeal activities in
25 accordance with section 133, the plan shall be treat-

1 ed as meeting the requirement of such section and
 2 is not liable for the entity's failure to meet any re-
 3 quirements under such section.

4 “(5) APPLICATION TO PROHIBITIONS.—Pursu-
 5 ant to rules of the Secretary, if a health insurance
 6 issuer offers health insurance coverage in connection
 7 with a group health plan and takes an action in vio-
 8 lation of any of the following sections, the group
 9 health plan shall not be liable for such violation un-
 10 less the plan caused such violation:

11 “(A) Section 109 (relating to non-
 12 discrimination in delivery of services).

13 “(B) Section 141 (relating to prohibition
 14 of interference with certain medical communica-
 15 tions).

16 “(C) Section 142 (relating to prohibition
 17 against transfer of indemnification or improper
 18 incentive arrangements).

19 “(D) Section 144 (relating to prohibition
 20 on retaliation).

21 “(E) Section 151 (relating to promoting
 22 good medical practice).

23 “(6) CONSTRUCTION.—Nothing in this sub-
 24 section shall be construed to affect or modify the re-

1 sponsibilities of the fiduciaries of a group health
2 plan under part 4 of subtitle B.

3 “(7) APPLICATION TO CERTAIN PROHIBITIONS
4 AGAINST RETALIATION.—With respect to compliance
5 with the requirements of section 144(b)(1) of the
6 Patients’ Bill of Rights Act of 1998, for purposes
7 of this subtitle the term ‘group health plan’ is
8 deemed to include a reference to an institutional
9 health care provider.

10 “(c) ENFORCEMENT OF CERTAIN REQUIREMENTS.—

11 “(1) COMPLAINTS.—Any protected health care
12 professional who believes that the professional has
13 been retaliated or discriminated against in violation
14 of section 144(b)(1) of the Patients’ Bill of Rights
15 Act of 1998 may file with the Secretary a complaint
16 within 180 days of the date of the alleged retaliation
17 or discrimination.

18 “(2) INVESTIGATION.—The Secretary shall in-
19 vestigate such complaints and shall determine if a
20 violation of such section has occurred and, if so,
21 shall issue an order to ensure that the protected
22 health care professional does not suffer any loss of
23 position, pay, or benefits in relation to the plan,
24 issuer, or provider involved, as a result of the viola-
25 tion found by the Secretary.

1 “(d) CONFORMING REGULATIONS.—The Secretary
 2 may issue regulations to coordinate the requirements on
 3 group health plans under this section with the require-
 4 ments imposed under the other provisions of this title.”.

5 (b) SATISFACTION OF ERISA CLAIMS PROCEDURE
 6 REQUIREMENT.—Section 503 of such Act (29 U.S.C.
 7 1133) is amended by inserting “(a)” after “SEC. 503.”
 8 and by adding at the end the following new subsection:
 9 “(b) In the case of a group health plan (as defined
 10 in section 733) compliance with the requirements of chap-
 11 ter 4 (and section 115) of subtitle A of the Patients’ Bill
 12 of Rights Act of 1998 in the case of a claims denial shall
 13 be deemed compliance with subsection (a) with respect to
 14 such claims denial.”.

15 (c) CONFORMING AMENDMENTS.—(1) Section 732(a)
 16 of such Act (29 U.S.C. 1185(a)) is amended by striking
 17 “section 711” and inserting “sections 711 and 713”.

18 (2) The table of contents in section 1 of such Act
 19 is amended by inserting after the item relating to section
 20 712 the following new item:

“Sec. 713. Patient protection standards.”.

21 (3) Section 502(b)(3) of such Act (29 U.S.C.
 22 1132(b)(3)) is amended by inserting “(other than section
 23 144(b))” after “part 7”.

1 **SEC. 302. ERISA PREEMPTION NOT TO APPLY TO CERTAIN**
2 **ACTIONS INVOLVING HEALTH INSURANCE**
3 **POLICYHOLDERS.**

4 (a) IN GENERAL.—Section 514 of the Employee Re-
5 tirement Income Security Act of 1974 (29 U.S.C. 1144)
6 is amended by adding at the end the following subsection:

7 “(e) PREEMPTION NOT TO APPLY TO CERTAIN AC-
8 TIONS ARISING OUT OF PROVISION OF HEALTH BENE-
9 FITS.—

10 “(1) IN GENERAL.—Except as provided in this
11 subsection, nothing in this title shall be construed to
12 invalidate, impair, or supersede any cause of action
13 brought by a plan participant or beneficiary (or the
14 estate of a plan participant or beneficiary) under
15 State law to recover damages resulting from per-
16 sonal injury or for wrongful death against any per-
17 son—

18 “(A) in connection with the provision of in-
19 surance, administrative services, or medical
20 services by such person to or for a group health
21 plan (as defined in section 733), or

22 “(B) that arises out of the arrangement by
23 such person for the provision of such insurance,
24 administrative services, or medical services by
25 other persons.

1 For purposes of this subsection, the term ‘personal
2 injury’ means a physical injury and includes an in-
3 jury arising out of the treatment (or failure to treat)
4 a mental illness or disease.

5 “(2) EXCEPTION FOR EMPLOYERS AND OTHER
6 PLAN SPONSORS.—

7 “(A) IN GENERAL.—Subject to subpara-
8 graph (B), paragraph (1) does not authorize—

9 “(i) any cause of action against an
10 employer or other plan sponsor maintain-
11 ing the group health plan (or against an
12 employee of such an employer or sponsor
13 acting within the scope of employment), or

14 “(ii) a right of recovery or indemnity
15 by a person against an employer or other
16 plan sponsor (or such an employee) for
17 damages assessed against the person pur-
18 suant to a cause of action under paragraph
19 (1).

20 “(B) SPECIAL RULE.—Subparagraph (A)
21 shall not preclude any cause of action described
22 in paragraph (1) against an employer or other
23 plan sponsor (or against an employee of such
24 an employer or sponsor acting within the scope
25 of employment) if—

1 “(i) such action is based on the em-
2 ployer’s or other plan sponsor’s (or em-
3 ployee’s) exercise of discretionary authority
4 to make a decision on a claim for benefits
5 covered under the plan or health insurance
6 coverage in the case at issue; and

7 “(ii) the exercise by such employer or
8 other plan sponsor (or employee) of such
9 authority resulted in personal injury or
10 wrongful death.

11 “(3) CONSTRUCTION.—Nothing in this sub-
12 section shall be construed as permitting a cause of
13 action under State law for the failure to provide an
14 item or service which is not covered under the group
15 health plan involved.”.

16 (b) EFFECTIVE DATE.—The amendment made by
17 subsection (a) shall apply to acts and omissions occurring
18 on or after July 1, 1999, from which a cause of action
19 arises.

1 **Subtitle D—Application to Group**
 2 **Health Plans Under the Internal**
 3 **Revenue Code of 1986.**

4 **SEC. 401. AMENDMENTS TO THE INTERNAL REVENUE CODE**
 5 **OF 1986.**

6 Subchapter B of chapter 100 of the Internal Revenue
 7 Code of 1986 (as amended by section 1531(a) of the Tax-
 8 payer Relief Act of 1997) is amended—

9 (1) in the table of sections, by inserting after
 10 the item relating to section 9812 the following new
 11 item:

“Sec. 9813. Standard relating to patient freedom of choice.”;
 and

12 (2) by inserting after section 9812 the follow-
 13 ing:

14 **“SEC. 9813. STANDARD RELATING TO PATIENTS’ BILL OF**
 15 **RIGHTS.**

16 “A group health plan shall comply with the require-
 17 ments of subtitle A of the Patients’ Bill of Rights Act of
 18 1998 and such requirements shall be deemed to be incor-
 19 porated into this section.”.

20 **Subtitle E—Effective Dates;**
 21 **Coordination in Implementation**

22 **SEC. 501. EFFECTIVE DATES.**

23 (a) GROUP HEALTH COVERAGE.—

1 (1) IN GENERAL.—Subject to paragraph (2),
2 the amendments made by sections 2201(a) and 2301
3 (and subtitle A insofar as it relates to such sections)
4 shall apply with respect to group health plans, and
5 health insurance coverage offered in connection with
6 group health plans, for plan years beginning on or
7 after July 1, 1999 (in this section referred to as the
8 “general effective date”).

9 (2) TREATMENT OF COLLECTIVE BARGAINING
10 AGREEMENTS.—In the case of a group health plan
11 maintained pursuant to 1 or more collective bargain-
12 ing agreements between employee representatives
13 and 1 or more employers ratified before the date of
14 enactment of this title, the amendments made by
15 sections 201(a) and 301 (and subtitle A insofar as
16 it relates to such sections) shall not apply to plan
17 years beginning before the later of—

18 (A) the date on which the last collective
19 bargaining agreement relating to the plan ter-
20 minates (determined without regard to any ex-
21 tension thereof agreed to after the date of en-
22 actment of this title), or

23 (B) the general effective date.

24 For purposes of subparagraph (A), any plan amend-
25 ment made pursuant to a collective bargaining

1 agreement relating to the plan which amends the
2 plan solely to conform to any requirement added by
3 this title shall not be treated as a termination of
4 such collective bargaining agreement.

5 (b) INDIVIDUAL HEALTH INSURANCE COVERAGE.—

6 The amendments made by section 202 shall apply with
7 respect to individual health insurance coverage offered,
8 sold, issued, renewed, in effect, or operated in the individ-
9 ual market on or after the general effective date.

10 **SEC. 502. COORDINATION IN IMPLEMENTATION.**

11 Section 104(1) of Health Insurance Portability and
12 Accountability Act of 1996 is amended by inserting “or
13 under subtitle A of the Patients’ Bill of Rights Act of
14 1998 (and the amendments made by such title)” after
15 “section 401)”.

16 **SEC. 503. NO IMPACT ON SOCIAL SECURITY TRUST FUND.**

17 (a) IN GENERAL.—Except as provided in section 606,
18 nothing in this title shall be construed to alter or amend
19 the Social Security Act (or any regulation promulgated
20 under that Act).

21 (b) TRANSFERS.—

22 (1) ESTIMATE OF SECRETARY.—The Secretary
23 of the Treasury shall annually estimate the impact
24 that the enactment of this title has on the income
25 and balances of the trust funds established under

1 section 201 of the Social Security Act (42 U.S.C.
2 401).

3 (2) TRANSFER OF FUNDS.—If, under para-
4 graph (1), the Secretary of the Treasury estimates
5 that the enactment of this title has a negative im-
6 pact on the income and balances of the trust funds
7 established under section 201 of the Social Security
8 Act (42 U.S.C. 401), the Secretary shall transfer,
9 not less frequently than quarterly, from the general
10 fund of the Treasury an amount sufficient so as to
11 ensure that the income and balances of such trust
12 funds are not reduced as a result of the enactment
13 of this title.

14 **Subtitle F—Revenue**

15 **SEC. 601. EXTENSION OF HAZARDOUS SUBSTANCE SUPER- 16 FUND TAXES.**

17 (a) EXTENSION OF TAXES.—

18 (1) ENVIRONMENTAL TAX.—Section 59A(e) of
19 the Internal Revenue Code of 1986 is amended to
20 read as follows:

21 “(e) APPLICATION OF TAX.—The tax imposed by this
22 section shall apply to taxable years beginning after De-
23 cember 31, 1986, and before January 1, 1996, and to tax-
24 able years beginning after December 31, 1999, and before
25 January 1, 2009.”

1 (2) EXCISE TAXES.—Section 4611(e) of such
2 Code is amended to read as follows:

3 “(e) APPLICATION OF HAZARDOUS SUBSTANCE
4 SUPERFUND FINANCING RATE.—The Hazardous Sub-
5 stance Superfund financing rate under this section shall
6 apply after December 31, 1986, and before January 1,
7 1996, and after December 31, 1999, and before October
8 1, 2008.”

9 (b) EFFECTIVE DATES.—

10 (1) INCOME TAX.—The amendment made by
11 subsection (a)(1) shall apply to taxable years begin-
12 ning after December 31, 1999.

13 (2) EXCISE TAX.—The amendment made by
14 subsection (a)(2) shall take effect on January 1,
15 2000.

16 **SEC. 602. CLARIFICATION OF DEFINITION OF SPECIFIED LI-**
17 **ABILITY LOSS.**

18 (a) IN GENERAL.—Subparagraph (B) of section
19 172(f)(1) of the Internal Revenue Code of 1986 (defining
20 specified liability loss) is amended to read as follows:

21 “(B) Any amount (not described in sub-
22 paragraph (A)) allowable as a deduction under
23 this chapter which is attributable to a liabil-
24 ity—

“(i) under a Federal or State law requiring the reclamation of land, decommissioning of a nuclear power plant (or any unit thereof), dismantlement of an offshore drilling platform, remediation of environmental contamination, or payment of workmen’s compensation, and

“(ii) with respect to which the act (or failure to act) giving rise to such liability occurs at least 3 years before the beginning of the taxable year.”

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to net operating losses for taxable years beginning after the date of the enactment of this Act.

**SEC. 603. PROPERTY SUBJECT TO A LIABILITY TREATED IN
SAME MANNER AS ASSUMPTION OF LIABILITY.**

(a) REPEAL OF PROPERTY SUBJECT TO A LIABILITY TEST.—

(1) SECTION 357.—Section 357(a)(2) of the Internal Revenue Code of 1986 (relating to assumption of liability) is amended by striking “, or acquires from the taxpayer property subject to a liability”.

1 (2) SECTION 358.—Section 358(d)(1) of such
 2 Code (relating to assumption of liability) is amended
 3 by striking “or acquired from the taxpayer property
 4 subject to a liability”.

5 (3) SECTION 368.—

6 (A) Section 368(a)(1)(C) of such Code is
 7 amended by striking “, or the fact that prop-
 8 erty acquired is subject to a liability,”.

9 (B) The last sentence of section
 10 368(a)(2)(B) of such Code is amended by strik-
 11 ing “, and the amount of any liability to which
 12 any property acquired from the acquiring cor-
 13 poration is subject,”.

14 (b) CLARIFICATION OF ASSUMPTION OF LIABIL-
 15 ITY.—Section 357(c) of the Internal Revenue Code of
 16 1986 is amended by adding at the end the following new
 17 paragraph:

18 “(4) DETERMINATION OF AMOUNT OF LIABIL-
 19 ITY ASSUMED.—For purposes of this section, section
 20 358(d), section 368(a)(1)(C), and section
 21 368(a)(2)(B)—

22 “(A) a liability shall be treated as having
 23 been assumed to the extent, as determined on
 24 the basis of facts and circumstances, the trans-
 25 feror is relieved of such liability or any portion

thereof (including through an indemnity agreement or other similar arrangement), and

“(B) in the case of the transfer of any property subject to a nonrecourse liability, unless the facts and circumstances indicate otherwise, the transferee shall be treated as assuming with respect to such property a ratable portion of such liability determined on the basis of the relative fair market values (determined without regard to section 7701(g)) of all assets subject to such liability.”

(c) APPLICATION TO PROVISIONS OTHER THAN SUBCHAPTER C.—

(1) SECTION 584.—Section 584(h)(3) of the Internal Revenue Code of 1986 is amended—

(A) by striking “, and the fact that any property transferred by the common trust fund is subject to a liability,” in subparagraph (A), and

(B) by striking clause (ii) of subparagraph (B) and inserting:

“(ii) ASSUMED LIABILITIES.—For purposes of clause (i), the term ‘assumed liabilities’ means any liability of the common trust fund assumed by any regulated

1 investment company in connection with the
 2 transfer referred to in paragraph (1)(A).

3 “(C) ASSUMPTION.—For purposes of this
 4 paragraph, in determining the amount of any li-
 5 ability assumed, the rules of section 357(c)(4)
 6 shall apply.”

7 (2) SECTION 1031.—The last sentence of section
 8 1031(d) of such Code is amended—

9 (A) by striking “assumed a liability of the
 10 taxpayer or acquired from the taxpayer prop-
 11 erty subject to a liability” and inserting “as-
 12 sumed (as determined under section 357(c)(4))
 13 a liability of the taxpayer”, and

14 (B) by striking “or acquisition (in the
 15 amount of the liability)”.

16 (d) CONFORMING AMENDMENTS.—

17 (1) Section 351(h)(1) of the Internal Revenue
 18 Code of 1986 is amended by striking “, or acquires
 19 property subject to a liability,”.

20 (2) Section 357 of such Code is amended by
 21 striking “or acquisition” each place it appears in
 22 subsections (a) and (b).

23 (3) Section 357(b)(1) of such Code is amended
 24 by striking “or acquired”.

1 (4) Section 357(c)(1) of such Code is amended
2 by striking “, plus the amount of the liabilities to
3 which the property is subject,”.

4 (5) Section 357(c)(3) of such Code is amended
5 by striking “or to which the property transferred is
6 subject”.

7 (6) Section 358(d)(1) of such Code is amended
8 by striking “or acquisition (in the amount of the li-
9 ability)”.

10 (e) EFFECTIVE DATE.—The amendments made by
11 this section shall apply to transfers after the date of the
12 enactment of this Act.

13 **SEC. 604. EXCISE TAX ON PURCHASE OF STRUCTURED SET-**
14 **TLEMENT AGREEMENTS.**

15 (a) IN GENERAL.—Subtitle D of the Internal Reve-
16 nue Code of 1986 (relating to miscellaneous excise taxes)
17 is amended by adding at the end the following:

18 **“CHAPTER 48—STRUCTURED**
19 **SETTLEMENT AGREEMENTS**

“Sec. 5000A. Tax on purchases of structured settlement agree-
ments.

20 **“SEC. 5000A. TAX ON PURCHASES OF STRUCTURED SETTLE-**
21 **MENT AGREEMENTS.**

22 “(a) IMPOSITION OF TAX.—There is hereby imposed
23 on any person who purchases the right to receive pay-

1 ments under a structured settlement agreement a tax
 2 equal to 10 percent of the amount of the purchase price.

3 “(b) EXCEPTION FOR COURT-ORDERED PUR-
 4 CHASES.—Subsection (a) shall not apply to any purchase
 5 which is pursuant to a court order which finds that such
 6 purchase is necessary because of the extraordinary and
 7 unanticipated needs of the individual with the personal in-
 8 juries or sickness giving rise to the structured settlement
 9 agreement.

10 “(c) STRUCTURED SETTLEMENT AGREEMENT.—For
 11 purposes of this section, the term ‘structured settlement
 12 agreement’ means—

13 “(1) any right to receive (whether by suit or
 14 agreement) periodic payments as damages on ac-
 15 count of personal injuries or sickness, or

16 “(2) any right to receive periodic payments as
 17 compensation for personal injuries or sickness under
 18 any workmen’s compensation act.

19 “(d) PURCHASE.—For purposes of this section, the
 20 term ‘purchase’ has the meaning given such term by sec-
 21 tion 179(d)(2).”

22 (b) CONFORMING AMENDMENT.—The table of chap-
 23 ters for subtitle D of the Internal Revenue Code of 1986
 24 is amended by adding at the end the following:

“CHAPTER 48. Structured settlement agreements.”

1 (c) EFFECTIVE DATE.—The amendments made by
 2 this section shall apply to purchases after the date of the
 3 enactment of this Act.

4 **SEC. 605. CLARIFICATION AND EXPANSION OF MATHEMATI-**
 5 **CAL ERROR ASSESSMENT PROCEDURES.**

6 (a) TIN DEEMED INCORRECT IF INFORMATION ON
 7 RETURN DIFFERS WITH AGENCY RECORDS.—Section
 8 6213(g)(2) of the Internal Revenue Code of 1986 (defin-
 9 ing mathematical or clerical error) is amended by adding
 10 at the end the following flush sentence:

11 “A taxpayer shall be treated as having omitted a
 12 correct TIN for purposes of the preceding sentence
 13 if information provided by the taxpayer on the re-
 14 turn with respect to the individual whose TIN was
 15 provided differs from the information the Secretary
 16 obtains from the person issuing the TIN.”

17 (b) EXPANSION OF MATHEMATICAL ERROR PROCE-
 18 DURES TO CASES WHERE TIN ESTABLISHES INDIVIDUAL
 19 NOT ELIGIBLE FOR TAX CREDIT.—Section 6213(g)(2) of
 20 the Internal Revenue Code of 1986 is amended by striking
 21 “and” at the end of subparagraph (I), by striking the pe-
 22 riod at the end of the first subparagraph (J) (relating to
 23 higher education credit) and inserting a comma, by redes-
 24 ignating the second subparagraph (J) (relating to earned
 25 income credit) as subparagraph (K) and by striking the

1 period at the end and inserting “, and”, and by adding
 2 at the end the following new subparagraph:

3 “(L) the inclusion of a TIN on a return
 4 with respect to an individual for whom a credit
 5 is claimed under section 21, 24, or 32 if, on the
 6 basis of data obtained by the Secretary from
 7 the person issuing the TIN, it is established
 8 that the individual does not meet any applicable
 9 age requirements for such credit.”

10 (c) EFFECTIVE DATE.—The amendments made by
 11 this section shall apply to taxable years ending after the
 12 date of the enactment of this Act.

13 **SEC. 606. MODIFICATION TO FOREIGN TAX CREDIT**
 14 **CARRYBACK AND CARRYOVER PERIODS.**

15 (a) IN GENERAL.—Section 904(c) of the Internal
 16 Revenue Code of 1986 (relating to limitation on credit)
 17 is amended—

18 (1) by striking “in the second preceding taxable
 19 year,” and

20 (2) by striking “or fifth” and inserting “fifth,
 21 sixth, or seventh”.

22 (b) EFFECTIVE DATE.—The amendments made by
 23 subsection (a) shall apply to credits arising in taxable
 24 years beginning after December 31, 1999.

1 (c) CREDIT OF REVENUES TO SOCIAL SECURITY
2 TRUST FUNDS.—

3 (1) ESTIMATE BY SECRETARY.—The Secretary
4 of the Treasury shall periodically estimate the in-
5 crease in Federal revenues for each of fiscal years
6 2000, 2001, and 2002 by reason of the amendments
7 made by this section. The Secretary shall adjust any
8 estimate to the extent necessary to correct any error
9 in a prior estimate.

10 (2) CREDIT OF FUNDS.—The Secretary of the
11 Treasury shall credit to the trust funds established
12 under section 201 of the Social Security Act (42
13 U.S.C. 401) the revenues raised as a result of the
14 enactment of this section. Such revenues shall be al-
15 located among the trust funds in the same manner
16 as other revenues.

17 **SEC. 607. INFORMATION REQUIREMENTS.**

18 (a) INFORMATION FROM GROUP HEALTH PLANS.—
19 Section 1862(b) of the Social Security Act (42 U.S.C.
20 1395y(b)) is amended by adding at the end the following:

21 “(7) INFORMATION FROM GROUP HEALTH
22 PLANS.—

23 “(A) PROVISION OF INFORMATION BY
24 GROUP HEALTH PLANS.—The administrator of
25 a group health plan subject to the requirements

1 of paragraph (1) shall provide to the Secretary
2 such of the information elements described in
3 subparagraph (C) as the Secretary specifies,
4 and in such manner and at such times as the
5 Secretary may specify (but not more frequently
6 than 4 times per year), with respect to each in-
7 dividual covered under the plan who is entitled
8 to any benefits under this title.

9 “(B) PROVISION OF INFORMATION BY EM-
10 PLOYERS AND EMPLOYEE ORGANIZATIONS.—An
11 employer (or employee organization) that main-
12 tains or participates in a group health plan sub-
13 ject to the requirements of paragraph (1) shall
14 provide to the administrator of the plan such of
15 the information elements required to be pro-
16 vided under subparagraph (A), and in such
17 manner and at such times as the Secretary may
18 specify, at a frequency consistent with that re-
19 quired under subparagraph (A) with respect to
20 each individual described in subparagraph (A)
21 who is covered under the plan by reason of em-
22 ployment with that employer or membership in
23 the organization.

1 “(C) INFORMATION ELEMENTS.—The in-
 2 formation elements described in this subpara-
 3 graph are the following:

4 “(i) ELEMENTS CONCERNING THE IN-
 5 DIVIDUAL.—

6 “(I) The individual’s name.

7 “(II) The individual’s date of
 8 birth.

9 “(III) The individual’s sex.

10 “(IV) The individual’s social se-
 11 curity insurance number.

12 “(V) The number assigned by the
 13 Secretary to the individual for claims
 14 under this title.

15 “(VI) The family relationship of
 16 the individual to the person who has
 17 or had current or employment status
 18 with the employer.

19 “(ii) ELEMENTS CONCERNING THE
 20 FAMILY MEMBER WITH CURRENT OR
 21 FORMER EMPLOYMENT STATUS.—

22 “(I) The name of the person in
 23 the individual’s family who has cur-
 24 rent or former employment status
 25 with the employer.

1 “(II) That person’s social secu-
2 rity insurance number.

3 “(III) The number or other iden-
4 tifier assigned by the plan to that per-
5 son.

6 “(IV) The periods of coverage for
7 that person under the plan.

8 “(V) The employment status of
9 that person (current or former) dur-
10 ing those periods of coverage.

11 “(VI) The classes (of that per-
12 son’s family members) covered under
13 the plan.

14 “(iii) PLAN ELEMENTS.—

15 “(I) The items and services cov-
16 ered under the plan.

17 “(II) The name and address to
18 which claims under the plan are to be
19 sent.

20 “(iv) ELEMENTS CONCERNING THE
21 EMPLOYER.—

22 “(I) The employer’s name.

23 “(II) The employer’s address.

24 “(III) The employer identifica-
25 tion number of the employer.

1 “(D) USE OF IDENTIFIERS.—The adminis-
2 trator of a group health plan shall utilize a
3 unique identifier for the plan in providing infor-
4 mation under subparagraph (A) and in other
5 transactions, as may be specified by the Sec-
6 retary, related to the provisions of this sub-
7 section. The Secretary may provide to the ad-
8 ministrators the unique identifier described in
9 the preceding sentence.

10 “(E) PENALTY FOR NONCOMPLIANCE.—
11 Any entity that knowingly and willfully fails to
12 comply with a requirement imposed by the pre-
13 vious subparagraphs shall be subject to a civil
14 money penalty not to exceed \$1,000 for each in-
15 cident of such failure. The provisions of section
16 1128A (other than subsections (a) and (b))
17 shall apply to a civil money penalty under the
18 previous sentence in the same manner as those
19 provisions apply to a penalty or proceeding
20 under section 1128A(a).”

21 (b) EFFECTIVE DATE.—The amendment made by
22 subsection (a) shall take effect 180 days after the date
23 of the enactment of this Act.